DRC INTEGRATED HIV/AIDS PROJECT

PROJET INTEGRE DE VIH/SIDA AU CONGO (PROVIC)
YEAR 1 ANNUAL REPORT

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Photos: ProVIC staff

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LIST OF ACRONYMS

AIDS	acquired immune deficiency syndrome
AMITIE	AIDS Mitigation Initiative to Enhance Care and Support in Bukavu, Lubumbashi, and Matadi
AMO-Congo	*Avenir Meilleur pour les Orphelins au Congo*
ART	antiretroviral therapy
BCC	behavior change communication
BDOM	*Bureau Diocésain des Oeuvres Médicales*
C-Change	Communication for Change
CCLD/Midema	Corporate Commitment for Local Development/Minoterie de Matadi
CODILUSI	Diocesan Committee in the Fight Against AIDS
CoP	Chief of Party
COP	Country Operational Plan
COTR	contracting officers' technical representative
CRS	Catholic Relief Services
CSR	*Centre de Santé de Reference*
DRC	Democratic Republic of Congo
DIVAS	Division des Affaires Sociales
ECC	*Eglise du Christ au Congo*
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	early infant diagnosis
FFP	*Fondation Femme Plus*
FHI	Family Health International
HBMM	*Hôpital Biamba Marie Mutombo*
HCT	HIV counseling and testing
HGR	*Hopitale General de Reference*
HIV	human immunodeficiency virus
HSS	health systems strengthening
IHAA	International HIV/AIDS Alliance
IR	intermediate result
M&E	monitoring and evaluation
MARP	most-at-risk population
MINAS	*Ministère des Affaires Sociales*
MSH/SPS	Management Sciences for Health/Strengthening Pharmaceutical Systems
MSM	men who have sex with men
NGO	nongovernmental organization
OVC	orphans and vulnerable children
PATH	Program for Appropriate Technology in Health
PCR	polymerase chain reaction
PEPFAR	US President's Emergency Plan for AIDS Relief
PICT	Provider Initiated Counseling and Testing

PLWHA	people living with HIV/AIDS
PMEP	Performance Monitoring and Evaluation Plan
PMTCT	prevention of mother-to-child transmission
PNLS	*Programme National de Lutte contre le SIDA*
PNMLS	*Programme Nationale Multi-Sectorielle de Lutte contre le SIDA*
PNSR	National Reproductive Health Program
PNT	*Programme National de Tuberculose* (National Tuberculosis Program)
ProVIC	*Projet Intégré de VIH/SIDA au Congo* (Integrated HIV/AIDS Project)
PSI/ASF	Population Services International/*Association de Santé Familiale*
PSSP	Progress and Health Without a Price (*Progrès Santé Sans Prix*)
SAF	Strategic Activities Fund
TB	tuberculosis
UCOP+	*Union Congolaise des Organisations des Personnes Vivant avec le VIH*
UNC	University of North Carolina
UNFPA	United Nations Population Fund
TOT	training of trainers
USAID	United States Agency for International Development
WHO	World Health Organization

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EXECUTIVE SUMMARY

The main objective of the Democratic Republic of Congo Integrated HIV/AIDS Project (ProVIC) is to reduce the incidence and prevalence of HIV/AIDS and mitigate its impact on people living with HIV/AIDS (PLWHA) and their families in the four provinces of Bas Congo, Katanga, Kinshasa, and Sud Kivu. ProVIC was awarded by USAID on October 1, 2009 to PATH, and its consortium, which includes Chemonics International, the Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), the International HIV/AIDS Alliance (IHAA), and Catholic Relief Services (CRS).[1]

This report on the first 12 months of ProVIC catalogues the many achievements and challenges associated with the start-up of activities for this complex and innovative project. Coupled with the realities of this post-conflict environment, the project made remarkable progress and inroads in such a short period. While achievements were registered, many challenges remain to be faced in the near future.

During the first six months of operations, an annual work plan, Performance Monitoring and Evaluation Plan (PMEP), and the President's Emergency Plan for AIDS Relief (PEPFAR) Country Operational Plan (COP) were developed and approved. Fully-functional field offices were opened in Kinshasa, Matadi, Lubumbashi, and Bukavu. All local personnel were hired in all four provincial offices, although we are currently seeking to fill the home-based care specialist position vacated by Catholic Relief Services (CRS). All offices are fully equipped with new administrative vehicles and office and communication equipment, including satellite phones for use in case of emergency. An emergency operations plan has been established in all four provincial offices and appropriate security awareness briefing completed for all staff. An organigram of ProVIC's key personnel is provided in Annex B.

During its first year, the project has built an impressive list of trusted partners at the central, provincial, and local government levels and among numerous grassroots communities, civil society, and the private sector. Through many interactive meetings, discussion groups, and workshops, the project team has shared its vision and strategies and explored numerous opportunities for close and active collaboration.

To ensure the continuity of some critical services provided under previous programs, ProVIC has issued a number of timely bridge grants to maintain activities in HIV counseling and testing (HCT) and provide support to PLWHA and orphans and vulnerable children (OVC). The project has also provided direct funding to many government health facilities and nongovernmental organization (NGO) implementing partners in an effort to compensate for delays in issuing new grants during the year. These direct interventions provided very important contributions to the targets met by the project during the reporting period.

A needs assessment study was carried out in the four project intervention provinces. Findings from these assessments have informed the project in its choice of intervention sites and development of its strategic intervention approaches.

[1] In July 2010, Catholic Relief Services (CRS) withdrew from the consortium. Their role was then filled by IHAA, who assumed the care and support portfolio hitherto managed by CRS (in addition to their role already held in health systems strengthening).

A key strategy around which the project's activities are built is the development of champion communities. Four pilot champion communities were created and set in motion during the first year. Scale-up to 40 champion communities is scheduled during the project's second year.

ProVIC Year 1 Achievements: Highlights

Community mobilization

316,302 of the targeted population reached with individual and/or small group level preventive interventions. A total of 31,172 most-at-risk individuals, including 16,661 truckers, 5,953 miners, 4,092 sex workers, 3,610 fishermen, and 392 men who have sex with men, reached.

HIV counseling and testing

77,936 people received testing and counseling services for HIV, including their test results.

Prevention of mother-to-child transmission (PMTCT) of HIV

6,881 pregnant women tested for HIV, and of those who were HIV positive, 99 received antiretroviral treatment to reduce risk of mother-to-child transmission.

Pediatric support

18 infants benefited from brand new technology and received an early infant diagnosis HIV test within 12 months of birth during the year. Thus far, all infants tested have been confirmed HIV negative—a testament to the effectiveness of PMTCT efforts.

Care and support

11,912 eligible adults and children provided with psychological, social, or spiritual support.

Health systems strengthening

458 health care workers successfully completed in-service training programs.

INTRODUCTION

The purpose of the Democratic Republic of Congo (DRC) Integrated HIV/AIDS Project (Projet Intégré de VIH/SIDA au Congo, ProVIC) is to bring about this much-needed change. Specifically, ProVIC aims to reduce the incidence and prevalence of HIV and mitigate its impact on people living with HIV/AIDS (PLWHA) and their families. We seek to achieve this objective by improving HIV/AIDS prevention, care and support, and treatment services in selected areas considered to be"hot spots" of HIV/AIDS infection in the DRC. To this end, we aim to increase and intensify community involvement in health issues and services beyond facility-based services.

Through its central strategy of building champion communities, ProVIC seeks to bring about change that reforms—and indeed, transforms—societies. This strategy includes fueling change in addressing and tackling the principal determinants and underlying conditions that make people and whole communities vulnerable to contracting HIV and AIDS. It also includes change from classic assistance (e.g., distribution of medicines, imported nutrition kits, and money) that has characterized international HIV/AIDS responses within the past few decades, to a more holistic, dignified approach guided by three principles: innovation, integration, and sustainability.

These principles that guide ProVIC's vision, strategies, and actions contain the essential ingredients for bringing about a self-reliant approach to the fight against HIV/AIDS. They encourage and empower national and regional governments and local communities to work in synergy and in close collaboration with each other. In this context, the grassroots community becomes the key point of departure and the sustainable core from which all HIV/AIDS-related interventions emanate.

In engaging members of the community to take the lead in identifying and defining their own problems, and collectively seeking and taking ownership of their own solutions, their own successes as well as failures, they become the architects of their own future. Aid in the form of projects like ProVIC serves as the catalyst for such change through targeted and contextualized awareness campaigns and training at the community level, behavior change initiatives, community mobilization, etc., to empower the community and hold it accountable to seek progress, resulting in a healthy community that is strong, cohesive, organized, confident, proud, self-reliant and productive, with a future for themselves, their children, and generations to come.

Giant masks and colorful costumes attract spectators to a community event on HIV/AIDS awareness. Photo: Salva Mulongo (ProVIC staff).

This report covers the period of October 1, 2009, to September 30, 2010, and is presented in three sections. Section 1 comprises activity reports by technical component: HIV/AIDS counseling and testing (HCT); care and support, and treatment for people living with HIV/AIDS and for orphans and vulnerable children in target areas and health systems

strengthening (HSS). Section 2 gives an overview of the program including cross-cutting issues such as monitoring and evaluation, grants management, administration and operations, gender and gender-related issues, and environmental compliance. Section 3 draws conclusions and outlines our perspective for the future not only of the project, but also of the communities we seek to impact and impact positively.

The activities, together with the relevant and pertinent experiences that came with them, provided us opportunities for taking a good and honest look at lessons learned and challenges to overcome. It presents an opportunity for us to evaluate our own performances during this period. In doing so, we must respect the customs and lifestyles of those we seek to impact and be cognizant of the need to delicately balance our zeal to bring about desired changes quickly, with the natural caution and hesitation that people express in dealing with change.

In submitting this report, we wish to acknowledge the contributions of many—from the USAID/DRC and Nairobi teams to the members of the consortium both in their home offices and in the field. We specifically wish to acknowledge the efforts of the USAID/DRC Health Team under the leadership of Michele Russell in accompanying ProVIC through this first year, and extend our deepest gratitude to ProVIC's outgoing contracting officers' technical representative (COTR), Dr. Laurent Kapesa, who provided daily support and guidance to us all. Finally, to our dedicated ProVIC staff, we thank you for your hard work and commitment during this first year of working together.

SECTION I: REPORTS BY TECHNICAL COMPONENT

Result 1: HCT and prevention services improved in target areas

Sub-IR 1.1: Communities' ability to develop and implement prevention strategies strengthened

Overview and strategy

The Champion Community is a participatory approach designed to mobilize and engage communities to define and undertake specific actions aimed at achieving or improving their health, social, and economic status. It involves active and informed participation of the whole community in the identification of health and development issues, determination of objectives or results to be achieved, implementation of specific activities, monitoring of these activities, and the collective enjoyment of concrete health outcomes**.**

The approach empowers communities, focuses on their internal strengths and weaknesses, mobilizes local resources, and develops mechanisms for attracting external resources**.** The approach has been applied to ProVIC because community engagement will further reinforce the success of all interventions by increasing demand for services such as HCT, prevention of mother-to-child transmission (PMTCT), and palliative care. While it is always challenging to identify and reach out to most-at-risk populations (MARPs) and other vulnerable groups, it is our hope and belief that reaching out to MARPs within the context of champion communities will not only enable us to support this target population, but will help shatter some of the issues around stigma and discrimination they face. It will also lead to more sustainable interventions, as activities will be planned and implemented through community mechanisms. This is particularly true of care and support, for which some activities will be coordinated through Champion Community partners.

The Champion Community approach stresses and capitalizes on the importance of the community in the local response to HIV/AIDS. It empowers communities to demand, access, utilize, and support existing HIV services—namely HCT/prevention, PMTCT, care and support for PLWHA and OVC, home-based care, and nutritional support. It is based on engagement and involvement of individuals, families, communities, associations, NGOs, civil society, and the business community to create dynamics that boost local participation in the planning, implementation, monitoring, and evaluation of the local response to HIV/AIDS. Lastly, this model increases and reinforces the capacity of communities to effectively respond to and mitigate the impact of HIV/AIDS, foster community leadership in ensuring high-quality services, establish strong linkages between communities and service delivery points, and leverage existing services to meet people's needs.

The Champion Community model is designed to promote gender equity by integrating both men and women in program activities, providing and facilitating access to family planning services and techniques. Further, it transforms social norms, practices, and behaviors that promote discrimination, marginalization, and stigmatization of vulnerable persons and groups. It also helps communities develop their own internal mechanisms for providing sustainable assistance and support to PLWHA, OVC, and families affected by HIV/AIDS. This results in the community taking ownership of both processes and outcomes.

Implementation of the Champion Community model is a seven-step process that begins with mobilization of and advocacy with political, religious, community, business, civil society, and government leaders. The second step consists of organizing the community into steering committees that include representatives of various populations and interest groups from different levels of the community (including PLWHA). Step three involves building the capacity of steering committee members and community volunteers to identify problems, define priorities, negotiate objectives, develop action plans, and sign an agreement supporting their plan. The fourth and fifth steps are effective implementation of these plans and regular monitoring and follow-up of community volunteers' activities by monitoring and evaluation (M&E) specialists and implementing partners (monitoring ideally takes place at the 100 and 200 day marks). The sixth step includes a self-evaluation and validation of the evaluation report to measure whether targets have been achieved. The seventh and last step is a celebration of achievements, with rewards and incentives that benefit the entire community.

During Year 1, ProVIC engaged a Malagasy consultant to help program staff understand the Champion Community approach and modify it to be responsive to the DRC context. As part of that process, a detailed implementation manual was developed along with guidelines for how to integrate the model into this specific program and its components.

Though the project experienced delays in getting the model off the ground, ProVIC staff did accomplish some of the critical advocacy at the national and regional levels to help government and civil society leaders understand the benefits of the approach and the plan for implementation.

In addition, program staff began some pilot activities by identifying one community in each region that met the criteria. They also began the initial steps with those communities in terms of forming the steering committees and identifying issues to be addressed within their context. These steps will be built upon in Year 2 of the program, as the model is more fully and completely rolled out.

Champion community model introduced and adapted to the DRC context

The ProVIC team identified and hired a Champion Community Specialist, Dr. Rija Fanomeza, to come to the DRC for several weeks to assist the Community Mobilization Specialist, Salva Mulongo, in the adaptation of the champion community model to the context of the DRC.

The technical assistance assignment took place in June and July 2010 and included consultations with government institutions, such as the Ministry of Health, PNMLS (*Programme Nationale Multi-Sectorielle de Lutte contre le SIDA*), and PNLS (*Programme National de Lutte contre le SIDA*), as well as with international and national NGO partners and beneficiaries.

The major output from this technical assistance was the development of a Champion Community Operations Manual that provides the team and our Champion Community partners with a step-by-step implementation guide. This manual was shared with ProVIC partners (C-Change, PNMLS, MINAS [Ministère des Affaires Sociales], Ministry of Gender and the Family, PNLS, UCOP+, RENOAC, the Society for Women and AIDS in Africa, and

others). Information exchanges were held to gather feedback and suggestions and answer any questions about the model.

Roll-out of the Champion Community model

During its first year, ProVIC identified four potential champion community sites where activities were initiated. Though the program was not ready to fully roll out the model on a wide scale using local partners, by starting in these four communities, we were able to pilot some of tools and determine the best kind of partners, communities, and material that could be used in a larger scale rollout in year 2. The four sites (Kinzau-Mvuete in the Bas Congo, Biyela in Kinshasa, Bagira in Sud Kivu, and Kampemba in Katanga), in ProVIC's four target regions, were selected based on the following criteria:

- Approximately 40,000 people in the target community.
- Geographic location (i.e., health area (*aire de santé*), schools and other social amenities in neighborhood.
- The presence of a strong community leadership.
- Community participation in HIV/AIDS prevention activities (e.g., nearby local partner organization engagement, counseling and testing services, care and support services, support and treatment).
- Willingness of the target community to engage in innovative, integrated, and sustainable activities.
- Existence of well-organized resources for awareness-raising activities; support and follow-up of PLWHA and OVC.
- Active engagement of women in HIV/AIDS interventions.

Women gather around a well for community outreach activities. Photo: Salva Mulongo (ProVIC staff).

In the process of rolling out the model in the communities, ProVIC identified several local partners who were well connected in those communities and would be strong assets in setting up and implementing the model. Table 1 below lists the identified communities as well as their corresponding local implementing partners:

Table 1. Local implementing partner, by community

Site number	Province	Zone de santé	Partner
1	Kinshasa	Biyela	Society for Women and AIDS in Africa
2	Bas Congo	Seke Banza	CEMAKI
3	Sud Kivu	Bagira	ProVIC Regional Coordination Office
4	Katanga	Kampemba	MUJI SAFI

To date, the ProVIC team has worked with its implementing partners to inform and educate community leaders, including representatives from the community development committees, health workers, women's groups, churches, school directors, and businessmen and women, on the Champion Community approach.

During meetings held with these leaders, the general approach and its potential impact on the community was discussed in order to generate enthusiasm and buy-in to the Champion Community process. Champion Community steering committees have been established in each of these four sites and ProVIC is working with local NGOs and these committees in planning and carrying out future Champion Community activities. In Year 2, these communities will benefit from this consolidation, drawing from lessons learned in Year 1.

Mass outreach activities in HIV/AIDS prevention conducted

Because the Champion Community approach was not fully rolled out during Year 1, ProVIC conducted outreach activities in other communities in order to reach MARPs and others in the general population. These activities were conducted both directly by ProVIC and through local partners.

Seven major themes were addressed, namely:

1. The importance of getting tested.
2. The importance of knowing one's sero status.
3. The consequences of contracting and living with sexually transmitted infections and HIV/AIDS.
4. The implication of MARPS in the fight against HIV/AIDS.
5. Mother-to-child transmission of HIV/AIDS.
6. Positive living and care and support for people living with AIDS.
7. Community involvement in the fight against HIV/AIDS.

A ProVIC peer educator engages schoolchildren in HIV/AIDS awareness discussions during their sports activities. Photo: Francis Mbala (ProVIC staff).

In order to improve the access of hard-to-reach MARPs to HIV services, joint community mobilization and mobile HCT operations were conducted in remote areas in each province. These interventions contributed to substantially boosting the results obtained under this indicator during the last quarter of the first year. A total of 26,575, or 85 percent, of the total number of MARPs reached during this year were directly attributable to these joint interventions.

Fairs and other special events were held in all four regions to reach people most at risk. Working closely with community activists, we used other advanced strategies, such as door-to-door outreach, educational chats, small group discussions, and video forums, to reach an even larger sector of the general population.

Other groups reached by the ProVIC team directly or through support given to partners, were student groups in close proximity to the University of Kinshasa campus, truck drivers, fishermen, and miners.

In total, 1807 events were held in the four ProVIC regions, reaching a total of 316,302 people with prevention messages.

Peer educators trained to disseminate HIV/AIDS messages

In addition to reaching out to MARPs and the general population, ProVIC has also organized training activities for peer educators who could then conduct other outreach activities and support the capacity building of local actors in mobilization around HIV/AIDS.

During the first year of the program, the ProVIC team, in partnership with PNLS, trained 357 peer educators in the four provinces on abstinence and being faithful (AB). When selecting the peer educators to train, our team focused on three types of groups:

- Life Clubs for school children.
- Hope Clubs for street kids.
- Young couples' clubs for church-based married couples.

Peer educators wrap up a training workshop on orphans and vulnerable children. Photo: ProVIC staff.

Each peer educator was provided with a toolkit, which included a bag, a t-shirt, a hat, an illustrated flipchart, a wooden phallus, HIV/AIDS information brochures (information, education, and communication materials), and condoms. These peer educator trainings allowed the team to reach students, out-of-school street children, and young couples.

In addition to peer educator activities, an outreach activity to school athletes was held in partnership with the Ministry of Primary and Professional Education. The activity mobilized more than 1000 primary and high school students, who benefitted from small group discussions (25 to 30 people per group) by ProVIC-trained peer educators. As a result of the remarkable success of this activity, the national and provincial Ministers of Primary and Professional Education have asked ProVIC to replicate this activity in the five other sub-divisions of Kinshasa during the second and subsequent project years.

Problems encountered and proposed solutions

The principal problems faced by the ProVIC team in its community mobilization activities were as follows:

- Delays in fully staffing and identifying technical assistance for the community mobilization component meant that activities did not get off the ground until the second half of the year, and even then, there was a steep learning curve for the ProVIC staff and partners in the nature of the approach and how to implement it. The hiring of the community mobilization specialist in May, coupled with the support of a Champion Community consultant in June/July, has prompted the launch of these activities. Further technical assistance from this consultant is planned for November/December 2010 to help with the training of ProVIC partners.
- Related to the above point, because the approach was still being articulated, the program has still not completed the development of all the requisite tools and behavior change

communication (BCC) materials, including those that would help document results that will be needed for implementation of the Champion Community model. The technical assistance planned for the second year will address this challenge.

- Another problem encountered was the demand of IPS (Provincial Health Inspection) to sign a specific Memorandum of Understanding with ProVIC before granting us the authorization to work with the health zones located in Kinshasa. This problem has now been resolved after productive working meetings with the Provincial Minister of Health and Social Affairs for the Province of Kinshasa.

Planned activities for Year 2

- Complete the process of adapting and validating the Champion Community approach for the DRC.
- Finalize the selection of NGO partners who will implement the approach.
- Organize the baseline study in the Champion Community areas.
- Develop the tools and materials for the implementation of champion communities.
- Train partners in the Champion Community approach.
- Develop BCC materials.
- Support implementation of champion communities in 40 sites.

Sub-IR 1.2: Community-based and facility-based HCT services enhanced

ProVIC's work in HCT emphasizes providing high-quality HCT services through different types of venues—government health centers, NGOs, faith-based organizations, and mobile clinics that focus on outreach to MARPs and other hard-to-reach populations. Site selection for HCT interventions focused on the targeted health zones in ProVIC's four regions and ensured that HCT services could be provided within zones that could support champion communities and other ProVIC services, such as care and support and PMTCT.

Implementation partners of this first year were those previously supported by USAID via Family Health International's RESA+ project. The program provided financial support and training to these NGO partners, as well as technical support and supervision visits to improve their skills, develop their ability to plan activities, and improve upon and/or achieve targeted results. Mobile HCT vehicles were also provided by ProVIC to enable NGO partners carry out Mobile HCT in remote, hard-to-reach communities. Recognizing the importance of carrying out these activities within the context of strengthening the DRC health system, ProVIC maintained a constant dialogue between communities and government partners and government institutions, such as PNLS, who were involved in designing the chosen strategic intervention approaches and in carrying out supportive supervision.

Establishment of successful partnerships for implementation

To ensure that all HCT activities are conducted in line with the established government policies and practices in DRC, reduce duplication, and create synergy in planning with other HIV/AIDS partners, ProVIC prioritized the participation of key government actors and other partners in planning and implementing its activities.

- **PNLS—**Through its partnership with PNLS, ProVIC provided technical assistance and, thereby, facilitated the adoption of the Provider Initiated Counseling and Testing (PICT) approach by PNLS, which is a priority for the government of the DRC. This approach is now being integrated into ProVIC's activities as well as in all PNLS-controlled intervention sites.
- **PNMLS—**ProVIC has also partnered with PNMLS to promote prevention and HCT activities in the four provinces covered by the project.
- **Population Services International/Association de Santé Familiale (PSI/ASF)—** Through consultations and planning, PSI and ProVIC agreed that PSI would conduct awareness and community mobilization campaigns within the context of ProVIC's Champion Communities and HCT sites. ProVIC and PSI/ASF agreed to collaborate on the reproduction of BCC tools and materials that PSI has developed and to adapt them for use in ProVIC sites and communities.

Ensured continuity of HCT services in sites previously supported by FHI

To ensure continuity in the delivery of HCT services following the closure of FHI's RESA+ project, ProVIC worked with previous FHI HCT sub-beneficiaries. In December 2009, ProVIC conducted a workshop in Kinshasa to support them in planning activities for 2010 and developing grants applications for continued funding. ProVIC worked with a total of 13 sites managed by *Foundation Femme Plus* (FFP), AMO-Congo (Avenir Meilleur pour les Orphelins au Congo), and World Production (3 in Bas Congo, 7 in Katanga, 2 in Sud Kivu, and 1 in Kinshasa). A detailed list of ProVIC-supported HCT sites is provided in Table 2 below.

Table 2: Year 1 ProVIC-supported HCT sites

Province	Health Zone	Sub-recipient	Name of structure	Types of HCT	Membership
Kinshasa	Matete	FFP	CD Matete	Community	ONG
		FFP	CD Matete	Mobile	ONG
	Masina I & II	PSSP	CD PSSP	Mobile	ONG
	Masina I & II	*Hôpital Biamba Marie Mutombo* (HBMM)	CD HBMM	PICT	Private
Bas Congo	Matadi	AMO-Congo	CD AMO-Congo 1	Community	ONG
	Nzanza	AMO-Congo	CD AMO-Congo 2	Community	ONG
	Matadi	AMO-Congo	CD AMO-Congo 3	Mobile	ONG
	Matadi	HGR Kiamvu	CD Kiamvu	PICT	Public
	Nzanza	HGR Kiamvu	CD Kiamvu	PICT	Public
	Nzanza	Jadi Sida	CD Jadisida	Mobile	ONG
	Kinzanvuete	Forum Sida	CD Fosi	Community	ONG

Province	Health Zone	Sub-recipient	Name of structure	Types of HCT	Membership
Katanga	Lubumbashi	CD World Production	CD World Production 1	CD mobile	ONG
	Rwashi	AMO-Congo	CD AMO-Congo 1 (CDV jeune)	CD community	ONG
	Kampemba	AMO-Congo	CD AMO-Congo 2	CD community	ONG
	Lubumbashi	AMO-Congo	CD AMO-Congo 3	CD mobile	ONG
	Kikula	World Production	CD World Production 2	Community	ONG
	Kipushi	World Production	CD World Production 3	Community	ONG
	Kasumbalesa	AMO-Congo	CD AMO-Congo 4	Community	ONG
	Kenya	HGR Kenya	CD Kenya	PICT	Public
	Panda	HGR Panda	CD Panda	PICT	Public
	Kampemba	HGR Kampemba	CD Kampemba	PICT	Public
	Lubumbashi	APEF	CD APEF	Mobile	ONG
	Lubumbashi	EFAM	CD EFAM	Mobile	ONG
Sud Kivu	Ibanda	FFP	FFP	Community	ONG
	Bagira /Ibanda	FFP	CD FFP	CD mobile	ONG
		HGR Nyantende	CD Nyantende	CD integrated	Public
		INEREC	CD INEREC	CD mobile	ONG

Once funding was confirmed, the national and regional prevention and HCT specialists carried out numerous capacity-building site visits, which emphasized the provision of high-quality services, targeting of MARPs, and the achievement of desired results and targets. These sites provided HCT services throughout the first year of the program and were responsible for significant contributions to program results.

Needs assessment of HCT services conducted and recommendations adapted

In the first half of the year, ProVIC conducted a qualitative and quantitative needs assessment study of the HCT partners inherited from RESA+ (FHI) to gather information on existing HCT structures and organizations in program intervention zones. Data were collected in 28 sites in three provinces—9 in Bas Congo, 10 in Katanga, and 9 in Sud Kivu using focus groups of service providers and beneficiaries. Staff from PNLS and PNMLS were also interviewed for their input. Data was not collected in Kinshasa because there were no previous FHI activities organized there.

SUCCESS STORY

Reaching new populations through mobile HIV testing

Photo: Francis Mbala (ProVIC staff).

Sébastien Ngala looks on as a community health worker draws his blood at a mobile HIV counseling and testing clinic.

Photo: Francis Mbala (ProVIC staff).

USAID's ProVIC project uses mobile HIV testing units and peer educators to link HIV/AIDS services with the people who need them.

Sébastien Ngala, a 28 year-old man, had just arrived at a mobile HIV counseling and testing site in the Kinshasa region after being contacted by a peer educator. He hesitated at first because of his unhealthy past and the number of casual partners he had known, but after speaking with the peer educator, and seeing some people around his age and others he recognized from his neighborhood, Sébastien agreed to get tested for HIV. He gave his blood sample, then refused to stand far from the tent as he anxiously awaited his results. The news that came was good news.

Sébastien jumped up with relief and exclaimed, "If this had been done in hospital, I never would have gone! Thank you for the services you have brought to the neighborhood." As he left the tent, showing off both his results and a few dance steps, he shouted, "I won't sleep anymore without a condom—and what's more, I'll come back with others!" Within minutes, Sébastien had been transformed from client into peer educator. By the end of the HIV awareness and testing sessions, he had single-handedly recruited 15 of his friends to come in for testing.

ProVIC has partnered with local NGO Progress and Health Without a Price (PSSP) to implement mobile counseling and testing in the Kinshasa region. These mobile units have surpassed expectations in their success with hard-to-reach populations such as commercial sex workers, fishermen, miners, and MSM. Mobile testing units place providers in the community, allowing them to better understand people's needs and initial resistance, and enabling peer educators to make personal contact with people and bring them to testing sites.

Following his positive experience at the mobile testing unit, Sébastien then helped catalyze a ripple effect that allowed ProVIC and PSSP to reach nearly 18,000 people. He has since been recruited by PSSP as a peer educator and continues to encourage friends his age to get tested.

Challenges encountered during the needs assessment and recommendations included the following:

- Poor functioning of referral and counter-referral systems for positive-tested clients, despite the availability of tools. Moreover, there had been no involvement of care and support organizations or the private sector in this study.
- Frequent stockouts of supplies, including HIV test kits and other HCT products, in health facilities.
- Little to no involvement of health zone staff in the supervision of HCT sites.
- Lack of confidentiality in dealing with patients/clients in some HCT centers.
- Lack of information, education, and communication (IEC) materials on the importance of testing at the community and health facility levels.
- Poor coordination of HCT activities with PNLS and PNMLS.
- No involvement of PLWHA in HCT activities.
- Stigmatization of clients at community HCT centers.
- Limited access to treatment services (antiretrovirals) and laboratory follow-up.
- Frequent changes in staffing of providers trained in HCT.
- Lack of motivation among service providers.

The results of this assessment formed the foundation for an integrated training workshop for service providers during the year. See the health systems strengthening section (Intermediate Result 3) for more information.

Selection of and support to new HCT sites

During the needs assessment process, the team also gathered data on health zones and facilities in order to create a prospective list of ProVIC implementation health zones and sites. Public-sector facilities located in critical health zones were selected to provide integrated services in those areas, particularly those offering PICT (provider-initiated counseling and testing). In addition to pre-selected public sector sites, ProVIC also planned to add new partners from NGOs, faith-based organizations, and community-based organizations that could provide valuable HCT services.

ProVIC's HCT specialist provided technical assistance to applicants during the RFA process to ensure that proposals developed reflected ProVIC's prevention objectives and strategies. This process was time-consuming given the volume of proposals received and relatively poor quality of many applications. Consequently, final selection of NGO HCT partners was delayed and is only now being finalized. We expect to have the final list of selected partners for USAID's requested review and approval by November 2010.

Due to delays in the grant award process, ProVIC directly supported the public health facilities and NGOs that were to conduct critical HCT activities in ProVIC intervention sites. These partners were able to rapidly scale up their activities in the second half of the year and reach significant numbers of people, including MARPS, with HCT services.

MSM and sex workers create a "buzz" for HIV counseling and testing

At the 2010 Kinshasa International Fair (FIKIN), MSM and sex worker peer educators of ProVIC partner PSSP were stationed at all FIKIN entrances. Passing from booth to booth, they identified and attracted their peers to the PSSP counseling and testing booths using attention-grabbing clothing, gestures, and chants. These "champions" engaged their peers in discussions on stigma surrounding HIV testing and distributed educational materials. Their attention-drawing techniques were so engaging that even the police facilitated the work of staff educators as they handed out pins to booth visitors.

Despite the confidential nature of HIV testing, many tested left the booth sharing their results with friends and partners. This helped combat stigma and foster community dialogue, acceptance, and even enthusiasm, encouraging others at high risk in the community to do the same. Outreach efforts continued well into the night!

To date, working with ProVIC, PSSP has reached 35,544 people, including 365 MSM and 450 CSW.

Some of the project's greatest successes came in the innovative use of mobile clinics, as ProVIC provided key organizations with access to cars, tents, and other materials and helped developed new strategies for targeting communities by geographic location and MARPs. Partners also used large trade and other fairs as opportunities to set up HCT centers that reached specific populations, such as youth.

Joint planning undertaken for the integration of family planning and TB with HCT services

The program conducted a number of consultations with PNLS and National Reproductive Health Program (PNSR) in integrating HCT with family planning counseling, since many facilities have a more cumbersome system of using two separate sets of counselors and two separate sets of data tools. ProVIC is supporting the finalization of a plan that would improve integration of critical policies and tools, such as the counseling sheets and data reporting tools, in the HCT system. The new integrated package will be fully rolled out in Year 2.

During Year 1, ProVIC also helped to develop a work plan with the *Programme National de Tuberculose* (The National Tuberculosis Program, or PNT) to help facilities improve their referral of HIV/AIDS clients to TB testing centers and vice versa. As a preliminary step, the PNT authorities have agreed to map HCT centers and centers for diagnosis and treatment of TB in ProVIC intervention zones as a way to facilitate greater integration and synergy between these service delivery channels.

Problems encountered and proposed solutions

- Procurement delays surrounding commodities for HIV/AIDS (specifically test kits) greatly delayed the implementation of HCT activities. The program is working on a longer term procurement plan to ensure continuous access to and availability of commodities by using local and international suppliers.
- Delays in the grants process affected the team's ability to fully roll out the HCT services early on. The direct assistance funding we offered to public health facilities (HGRs and CSRs) and a few NGOs to carry out critical HCT activities in ProVIC intervention sites allowed us to launch activities in quarters 3 and 4 and come closer to reaching our HCT targets. The updated grants strategy and grantees, which will be submitted to USAID in November should resolve this challenge we faced in Year 1.

- There is a lack of participation among the Health Authorities (health zones) in the supervision of community and mobile HCT clinics, which do not report back to health zones. ProVIC staff has worked (and will continue to do so), with health zone teams to ensure their participation in joint supervision activities and encourage PNLS to work closely with the health units.
- The current referral and counter-referral system for clients who have tested positive for HIV has not been effective despite the existence of the necessary tools. ProVIC plans to bring the private, public, and community sectors together to create a stronger network as well as finalize a complete mapping of all available services in the various areas of intervention to increase the effectiveness of the referral/counter-referral system.
- Many HCT service providers are discouraged by the time lag in receiving funding for their activities. The ProVIC staff will assist the HCT services develop their project proposal in the first quarter in order for them to begin their activities as soon as possible.
- Many HCT clinics lack the appropriate counseling rooms to offer confidentiality for HCT activities.
- Mobile HCT clinics do not have the right tents or equipment to ensure confidentiality. ProVIC is looking into equipment purchases at this time that will address this problem.
- There is a poor understanding of provider-initiated counseling and testing (PICT), which will be addressed through training in year 2.
- Poor management of biomedical waste has been an issue this year, but we have seen great improvements thanks to sustained ProVIC support. All ProVIC intervention sites will continue to benefit from high standards of biomedical waste management.
- There has been great mobility and loss of ProVIC trained HCT counselors who seek new and better-paying jobs after acquiring new skills pursuant to receiving training from our program. This turnover is particularly seen at government sites. ProVIC will work with the DRC government to try to figure out how to minimize this phenomenon.
- On-site trainings for more than one service provider will be conducted in each site covered by ProVIC.

Anticipated activities and plans for Year 2

- Continue supporting existing HCT centers.
- Integrate family planning activities with community, public, and mobile HCT centers.
- Provide sufficient support to open new HCT centers in Champion Communities.
- Ensure consistent commodity supply in HCT facilities.
- Organize the referral and counter-referral systems.
- Ensure HCT service quality in testing sites.
- Continue ensuring effective management of biomedical waste in HCT centers.

Sub-IR 1.3: PMTCT services improved

Summary of Year 1 activities and achievements

A nurse congratulates an HIV-positive mother on her newly delivered twins at an EGPAF partner hospital in Kinshasa. Photo: Gabrielle Bielen (EGPAF).

In Year 1, the ProVIC PMTCT team conducted a needs assessment in four provinces to identify potential PMTCT sites and determine priorities for project activities. In consultation with PNLS, 16 sites were selected as ProVIC PMTCT sites and 8 AXxes PMTCT sites were selected for targeted technical assistance. ProVIC advocacy at the national level was instrumental in the incorporation of new World Health Organization (WHO) recommendations into the national guidelines for PMTCT and pediatric care and treatment. Health care providers, district health officials, and AXxes staff were trained in HIV service provision according to the national integrated training model and received special instruction on the new PMTCT and pediatric care guidelines and the importance of integrating provider- initiated counseling and testing into PMTCT services. Detailed capacity-building plans were established for targeted AXxes PMTCT sites within ProVIC's geographic area. A network was developed to provide early infant diagnosis services to HIV-exposed infants, and a mapping exercise pinpointed the location of sites offering pediatric care and treatment.

Government capacity strengthened to provide PMTCT services

A key focus in Year 1 was advancing the agenda of the technical working group on PMTCT and pediatric HIV in line with new WHO guidelines. ProVIC played a critical role in moving this dialogue forward at the national level, as PMTCT Specialist Dr. Ditekemena served as the technical lead for the group. Throughout the year the ProVIC PMTCT team (consisting of PMTCT Specialist Dr. Ditekemena and Pediatric Specialist Dr. Katabuka) initiated and participated in numerous meetings and workshops with partners involved in HIV activities in the DRC. These meetings aimed to reinforce and strengthen the capacity of the DRC government to provide and supervise high-quality PMTCT and pediatric care services for children affected by HIV. Critical stakeholders included PNLS, PNMLS, the Clinton Foundation, Management Sciences for Health (MSH), UNICEF, WHO, and the Kinshasa School of Public Health.

Quantitative and qualitative needs assessment conducted and recommendations implemented

In January 2009, the ProVIC PMTCT specialist developed a protocol to conduct a needs assessment in the provinces where the project operates: Sud Kivu, Bas Congo, Katanga, and Kinshasa. The general objective of the evaluation was to gather a baseline of medical, demographic, and administrative data on facilities and health zones for potential intervention by ProVIC in Matadi, Kinshasa, Bukavu, and Lubumbashi. The PMTCT team collected and analyzed quantitative and qualitative data related to PMTCT service provision and identified gaps in existing PMTCT services in order to propose strategies and interventions to improve services. The needs assessment facilitated the identification of potential ProVIC PMTCT sites. As a result, 24 PMTCT sites were identified for start-up activities in Year 1.

The quantitative assessment was conducted in January and the qualitative assessment in March. Some of the most pressing gaps identified during the assessment included poor linkages between PMTCT and other maternal and child health services; extremely low levels of male partner involvement in PMTCT; huge breaks in the continuum of care (nonexistent or inaccessible treatment options for HIV-positive pregnant women and their infants); lack of or deficient mentoring for clinic staff; and poorly structured client flow resulting in service delays and client loss. Based on these findings, the following interventions were developed to address these gaps:

- Client flow changes were introduced to simplify antenatal care services and improve confidentiality.
- HIV counseling and testing was introduced during labor and delivery.
- Changes to clinic hours were suggested to encourage male partner involvement.
- CD4 testing was improved by training providers on collecting samples at project PMTCT sites and sending them for testing, rather than referring clients away from these sites for testing elsewhere.
- Supportive supervision visits were conducted jointly with health zone staff to improve monitoring of activities and their understanding of site needs.

PMTCT and pediatric care guidelines revised

As noted above, the ProVIC PMTCT team led several meetings aimed at encouraging the Ministry of Health/PNLS to revise national PMTCT and pediatric care guidelines in line with recent international recommendations from WHO. The government was initially reluctant about the idea of updating the national protocol because the previous change from single-dose nevirapine to combined regimens beginning at 28 weeks for PMTCT prophylaxis, adopted in 2007, was never successfully implemented due to lack of supplies and human resource limitations. Drs. Ditekemena and Katabuka worked closely with UNICEF and WHO to convince PNLS of the importance and feasibility of revising these guidelines given that Global Fund Round 10 will use PMTCT as an entry point to care. They also worked with UNICEF, WHO, and PNLS to develop the agenda and scope of work for a series of guideline revision workshops, the first of which was held from June 23 to 25, 2010.

ProVIC leads revision of national guidelines

- Dr. Ditekemena led a national working group on PMTCT and pediatric care guideline revision.
- ProVIC team planned meeting agendas.
- PMTCT team led PNLS and partners through advantages/disadvantages of various WHO options for PMTCT and pediatric care in low-resource settings.
- Dr. Ditekemena drafted new national guidelines.

The ProVIC PMTCT team took a leadership role in drafting and then finalizing the first version of the new guidelines, as well as coordinating the workshop and explaining WHO guidelines and then participating in the subsequent validation workshop. Based on their recommendations, the country opted for Option A, which is more appropriate for low-resource settings on the basis of acceptability, cost, feasibility of implementation, potential for adverse effects, and resistance and ability of the health system to maintain reaching high numbers of women with appropriate PMTCT interventions. Option A introduces maternal AZT starting as early as 14 weeks, single-dose nevirapine at the onset of labor, and AZT and 3TC during labor and delivery and for 7 days post partum. Breastfeeding infants receive daily nevirapine until one week after the cessation of labor (recommended at one year by PNLS).

Option B provides for maternal triple ARV prophylaxis from 14 weeks until one week after the cessation of breastfeeding and infant AZT, or nevirapine for 4 to 6 weeks for both breastfed and non-breastfed infants. The entire process was a great success in terms of capacity building at the national level, and throughout the ProVIC team played a key role in providing education, advocacy, and technical advice. As a result of these national-level discussions, the DRC has adapted new PMTCT and pediatric care guidelines based on the latest 2009 WHO recommendations.

Providers trained in provider-initiated counseling and testing in PMTCT context

The ProVIC PMTCT team participated in preparing and administering a series of trainings of trainers (TOTs) for the "National Integrated HIV Module" in collaboration with PNLS. The series began with a high-level TOT in Kinshasa and continued with trainings of providers in Kinshasa, Matadi, Bukavu, and Lubumbashi led by newly-trained TOTs. During the trainings, the integrated module (adopted by PNLS in November 2009) was used to highlight the importance of integrating PICT with maternal and child health and PMTCT services.

The participants in the TOT (20 per province) were selected from the staff of health zones, PNLS, and General Hospitals associated with ProVIC health zones and facilities. After the training these new trainers (including Dr. Katabuka) had the opportunity to test their new skills by leading a training of providers under the supervision of members of the national pool of expert trainers (including PMTCT Specialist Dr. Ditekemena). The cascade of training of providers took place June 15–24, 2010. Participants for the trainings of providers were chosen from the sites and facilities where ProVIC is implementing activities. Participants included are outlined in Table 3 below.

Table 3. Numbers of trainers and providers trained, by province

Province	Type of participants	Training of trainers	Training of providers
Kinshasa	Physicians	14	21
	Lab technicians	5	8
	Nurses	8	20
Katanga	Physicians	6	10
	Lab technicians	4	10
	Nurses	2	9
Sud Kivu	Physicians	4	7
	Lab technicians	6	8
	Nurses	4	8
Bas Congo	Physicians	4	7
	Lab technicians	4	7
	Nurses	3	14
TOTAL		64	129

Selected participants from local NGOs and district health officials were also included in the training. In follow-up, the PMTCT team is now supporting the capacity of all ProVIC PMTCT sites to implement PICT during labor and delivery.

Early infant diagnosis of HIV introduced in DRC

The ProVIC PMTCT also used the training of providers as an opportunity to train lab technicians in Early Infant Diagnosis (EID). The PMTCT team advocated for, and received supplies for EID from PNLS (originating from the Clinton Foundation). PNLS has agreed to continue to provide these materials as long as their support from the Clinton Foundation continues. During the first phase of testing in Q4, 18 infants were among the first to be tested in the country. Three were found to be positive and referred to pediatric care facilities, and all 18 were started on cotrimoxazole.

ProVIC's PMTCT program is one of very first to create a network for collecting and transporting samples and returning EID results to families in the DRC. In August, Dr Katabuka first established this network for collecting, transferring, testing, and then returning results to sites and families throughout the four provinces. All samples are sent to Kinshasa for PCR analysis. Once test results are ready, the pediatric specialist calls the regional prevention specialist to communicate these results, following up with an email explanation. Hard copies are then sent to testing sites via DHL or another appropriate courier.

ProVIC initiates EID network

- 18 infants among first to be tested in country.
- Specimen transportation network developed to initiate testing in all ProVIC provinces.
- Results returned from national laboratory in Kinshasa via telephone within 24 hours of receipt.

In addition, ProVIC worked with PNLS and the Clinton Foundation to collect data and produce a document illustrating existing pediatric care and treatment sites in ProVIC provinces. This will be the foundation of further pediatric health activities in Year 2.

Quality of PMTCT in AXxes sites improved

As part of the ProVIC needs assessment, PMTCT staff also conducted specific assessments at selected AXxes sites in areas targeted by ProVIC (i.e., Sud-Kivu and Katanga). The resulting detailed report regarding AXxes sites identified gaps and suggested strategies for bridging these gaps.

In May, the PMTCT specialist conducted a training workshop for the AXxes project in Bukavu. Participants included AXxes supervisors, the national AXxes PMTCT coordinator, the PNSR (National Program for Reproductive Health) provincial coordinator, and two PNLS provincial supervisors. During this workshop, gaps identified during the needs assessment were discussed with participants and appropriate strategies and problem-solving methods to address these gaps suggested. For example, formally inviting male partners to the facility using a paper invitation was suggested to encourage male participation. Working together with the AXxes PMTCT coordinator in Kinshasa and AXxes team leaders on the ground, the ProVIC PMTCT team guided the development of a four-month capacity-building plan. ProVIC and AXxes also agreed to convene bi-weekly technical meetings to allow regular follow-up on the implementation of recommendations in the capacity-building plan and provide further technical and troubleshooting support from the ProVIC team.

SUCCESS STORY

Early infant diagnosis: New technology gives life-changing information to mothers

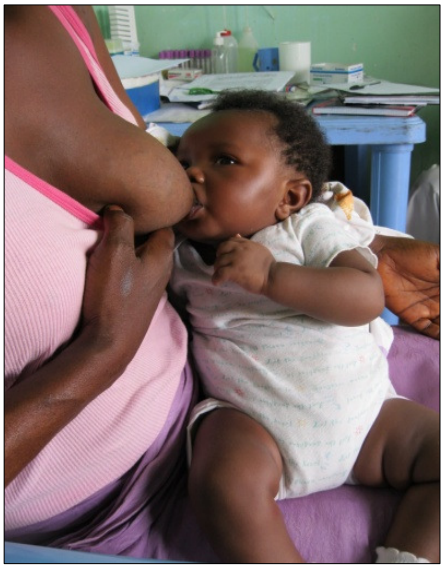


Photo: Mitterand Katabuka (ProVIC staff.)

Infant Nzuzi, born from an HIV-positive mother on ART, tested HIV negative at two months of age.

"Since I started ART, my health has really improved; however, I was very afraid about my infant's HIV status. Initially, I was asked to wait for 18 months for my baby to get tested, and that was stressful for me. When I learned that this kind of early test had become available at my maternity, I presented myself the following day to learn more and find out my baby's HIV status. Today, I am very happy to know that he is not positive. This relieves me of the stress which I was going to have to manage waiting for 18 months to know his status."
~ Nzuzi's mother

Baby "Nzuzi" (not his real name), pictured at left, was the third child of his family born to an HIV-positive mother in the DRC. Nzuzi's mother had just started antiretroviral therapy (ART), thereby reducing the risk of her infecting Nzuzi during pregnancy, labor, and breastfeeding, and she was very eager to find out Nzuzi's HIV status and know the kind of care and support he would need right away.

Before ProVIC introduced early infant diagnosis (EID) for HIV, Nzuzi's mother would have had to wait 18 months before he could be tested, preventing him from receiving critical early interventions and treatment had he tested positive.

Now the maternity center where Nzuzi's mother delivered could give her an answer a lot sooner. She brought Nzuzi back to the center when he was two months old. A drop of blood was collected from his heel, and the sample was transferred through the ProVIC EID network to the national laboratory for testing. A negative test result arrived one week later.

Early infant diagnosis for HIV-exposed infants became a possibility in the DRC in 2010 thanks to collaborations between the PEPFAR-funded USAID ProVIC project, the National AIDS Control Program (PNLS), and the latter's support from the Clinton Foundation. This intervention was officially launched in August 2010 at a ceremony at the national laboratory in Kinshasa, which houses the project's HIV testing equipment.

New technology leveraged by ProVIC's EID services has allowed for testing of infants as young as six weeks old, and hence the possibility of early treatment for infected infants who would otherwise suffer extremely high rates of mortality during their first two years of life. Through ProVIC, transportation networks have been established to test infants living in Katanga, Kinshasa, Sud Kivu, and Bas Congo.

During his August visit to Bukavu to follow up on implementation of the ProVIC-AXxes capacity-building plan, pediatric specialist Dr. Katabuka found the implementation to be behind schedule. AXxes staff explained that they were focused on other activities and had not had time to implement proposed recommendations. The AXxes team was also concerned that their project was scheduled to close in September 2010. Dr. Katabuka encouraged the AXxes team in Bukavu to prioritize the capacity-building plan to ensure that patients would receive the highest-quality clinical services, using the regional visit as an opportunity to verify the quality of PMTCT activities at ProVIC sites by using supportive supervision and mentorship techniques with providers at ProVIC PMTCT sites.

The PMTCT specialist, Dr. Ditekemena, also provided technical assistance to the AXxes project in Katanga. He provided feedback on the main programmatic weaknesses observed to at visited AXxes sites e.g. breaches of confidentiality, poor management of biological and medical waste, etc. Together with the provincial AXxes team and the national PMTCT coordinator for AXxes, a capacity building plan was developed for AXxes sites in Katanga. A follow up-visit to monitor the progress of the Katanga sites according to the capacity building plan is planned for December 2010, by which time a new partner will be taking them over.

Access to PMTCT services increased

Memoranda of Understanding were signed between ProVIC and partners for 16 PMTCT sites: 4 in Kinshasa, 5 in Bas Congo, 2 in Bukavu, and 5 in Lubumbashi. They included the terms of collaboration, consisting of main activities, total budget, and procedures for reporting. These sites received financial support from ProVIC starting in July to support PMTCT activities. All 16 sites had previously provided some type of PMTCT intervention, but in most cases the quality of programming was lacking or funding insufficient to continue PMTCT activities.

ProVIC targets for Year 1 were to implement PMTCT activities at 16 ProVIC sites and to support and improve PMTCT activities at 8 AXxes sites. ProVIC provided technical assistance to AXxes at the national as well as at provincial level. These capacity building efforts were designed to help them to improve the quality of PMTCT activities at all AXxes sites. Eight sites were selected to receive special technical assistance, such as site visits and joint ProVIC-led supervisions to help them develop as model PMTCT sites and serve as examples for other AXxes sites. These targets were met by the team during the second half of Year 1. ProVIC PMTCT activities currently span 17 health zones.

In addition to these direct activities, ProVIC is closely following the CEDRAS Operational Research study, being conducted by the Kinshasa School of Public Health (KSPH)/University of North Carolina (UNC) team with independent financial support from EGPAF. The study aims to identify the reasons why most HIV-positive women in DRC do not return to the same maternity where they received antenatal care services for delivery. CEDRAS has been engaged in assessing the qualitative, psychological, and anthropological aspects of this issue at study sites throughout Kinshasa. The PMTCT specialist is working with UNC staff to follow the results of this study in order to integrate pertinent findings into ProVIC PMTCT activities. Research results should allow providers to better address barriers women face to delivering in the same maternities where they access antenatal care services. The CEDRAS study is still in progress. Preliminary results were shared during a one day workshop attended by the ProVIC PMTCT team on August 13, 2010.

The ProVIC team is collaborating with the study team to receive additional information on the preliminary results and ongoing updates in order to inform Year 2 planning. Final results from the study are anticipated by July 2011. Table 4 lists ProVIC PMTCT sites by region.

Table 4. ProVIC PMTCT sites

Region	Site name	Health zone	AXxes
Kinshasa	Kingasani Maternity	Kingasani	No
	Binza Maternity	Binza Metéo	No
	Kikimi General Hospital	Kikimi	No
	Libonzi Health Center	Bumbu	No
Bas Congo	Kinsundi Health Center	Lukula	No
	Lukula General Hospital	Lukula	No
	Kalamu Health Center	Boma	No
	Kinzau Mvuete Health Center	Sekebanza	No
	Nvuzi Health Center	Nzanza	No
Katanga	Kenya General Hospital	Kenya	No
	Kampemba General Hospital	Kampemba	No
	Kasumbalesa Health Center	Sakania	No
	Panda General Hospital	Panda	No
	Mary Elmer Health Center	Kampemba	No
	Kanzenze General Hospital	Manika	Yes
	Lwalaba Health Center	Lwalaba	Yes
Sud Kivu	CIDASA	Ibanda	No
	Malkia wa amani	Ibanda	No
	Philadelphie Clinic	Ibanda	Yes
	CEPAC Buholo Health Center	Kadutu	Yes
	Nyamugo CBCA Health Center	Kadutu	Yes
	Bagira General Hospital	Bagira	Yes
	Kilomoni Health Center	Uvira	Yes
	Kalundu Etat Health Center	Uvira	Yes

Problems encountered and proposed solutions

- Delay in implementation of PMTCT activities due to delay providing financial support to PMTCT sites. Getting the granting process started at the consortium level took much longer than anticipated during Year 1. This situation affected all partners and had an impact on programmatic activities, leading to the delay of clinical services and attainment of targets. PMTCT services did not begin until July, after the consortium had decided to move away from grants to using direct funding for PMTCT activities. Given the difficulty of finding facilities to provide PMTCT services with the capacity of applying for grants, it has been decided that the consortium will continue to use direct funding for PMTCT activities throughout the life of the project.

- Lack of critical medical commodities for PMTCT and pediatric care. Due to delays in determining the process for obtaining commodities, since ProVIC had not originally planned on procuring pharmaceuticals as we had expected these would be available via other donors, such as the Global Fund and Clinton Foundation, ProVIC did not have drugs available for PMTCT or pediatric care this year. In April/May 2010, the PMTCT team worked with a commodities consultant on drug quantification to determine what specific drugs were needed and the cost, and to identify potential suppliers. Identifying a

supplier who could provide ARVs and cotrimoxazole rapidly, while meeting the strict regulatory criteria of having all drugs certified as USFDA approved, proved particularly challenging. The first waiver request sent to USAID for approval in July 2010 was rejected, but the second waiver was approved in September, and we are now waiting for the order of essential drugs for PMTCT and pediatric care to arrive in-country.

Most ProVIC PMTCT sites are currently using Global Fund drugs on loan through PNLS. All PMTCT sites are using single-dose nevirapine for PMTCT prophylaxis until combination regiments become available. A six-month supply of combination drugs was promised by PNMLS to the Chef of Party in September 2010, but these arrangements are still pending and no commodities have reached the sites. Another gap in PMTCT programming is the lack of cotrimoxazole, which is also expected in the new drug order. Cotrimoxazole should be taken by all HIV-positive pregnant women and their exposed infants to prevent opportunistic infections and malaria.

- Confusion around the aggregation of PEPFAR indicators. Some PEPFAR indicators included in the Year 1 Country Operational Plan were not easily disaggregated. For example, the indicator related to the number of infants tested within 12 months, C4.1D, "% of infants who received an HIV test within 12 months of birth during the reporting period," was disaggregated as follows:
  - Infants who were tested virologically for the first time between 2 and 12 months.
  - Infants who had an antibody test between 9 and 12 months.

In DRC, PCR testing for EID is recommended at six weeks (which is before the two-month disaggregation). In addition, the antibody test is recommended in DRC at 18 months (which is after 12 months in the disaggregation. This disaggregation led to confusion, but the same indicator did not appear in the newest version of the PEPFAR indicators found in the latest Country Operational Plan.

Planned activities for Year 2

- Strengthen government capacity to provide PMTCT services.
- Increase promotion and uptake of pediatric counseling and testing and improve follow-up of mothers and infants.
- Provide technical assistance and capacity building in PMTCT to former AXxes sites which are located in geographic areas targeted by ProVIC.
- Increase the quality of PMTCT services provided.
- Improve access to comprehensive PMTCT services.

Result 2: Care, support, and treatment for people living with HIV/AIDS and for orphans and vulnerable children improved in target areas

Summary of activities and achievements

Building on the activities led by CRS under the AMITIE project (AIDS Mitigation Initiative to Enhance Care and Support in Bukavu, Lubumbashi, and Matadi), ProVIC activities centered around the community, adopting the US Government's strategy of integrating palliative care into the framework of the Family-Centered Continuum of HIV services involving PLWHA and OVC to ensure effective and measurable participation of PLWHA and those affected by HIV, families, staff, community networks of care and support to

PLWHA and care referral systems (health and community structures). ProVIC supported PNLS and MINAS in developing and disseminating standard packages of services to expand service range and coverage. At the provincial level, ProVIC worked with PNLS, the Ministry of Public Health, and PNMLS to foster integration and institutionalization of our activities into provincial social and health systems.

Sub-IR 2.1: Care and support for PLWHA strengthened

Sub-IR 2.2: Care and support for OVC strengthened

For people living with HIV/AIDS, we worked to improve the clinical aspects of palliative care and provide a holistic package of care and support interventions that improve both their health and socioeconomic status. This included interventions such as the promotion of a positive living strategy (through the development of a positive living guide); development of high-quality palliative care packages; supply of a range of kits to PLWHA; protection of PLWHA through access to legal services and combating stigma and discrimination; integration of home-based palliative care; improvements to nutrition; social entrepreneurship; vocational education; professional training; and income-generating activities. In addition, the project worked with MINAS to implement PAN/OVC community-level activities and developed a new, comprehensive package of support for OVC using the same holistic approach to improving a child's well-being.

Photo: Nathalie Albrow (PATH).

To support the practical implementation of these strategies, bridge grants were made available to former CRS/AMITIE partners. Further, ProVIC worked with strategic partners such as UCOP+ to cover the work on positive living, develop the positive living guide, and produce IEC materials. Other partners were also able to benefit from ProVIC's direct support in order to carry out care and support actions.
It should be noted that ProVIC's care and support activities were led by CRS in Year 1. However in July 2010 CRS withdrew from the consortium and the International HIV/AIDS Alliance, which was already leading the project's health systems strengthening activities, assumed the responsibility for this component.

Bridge funding for AMITIE grantees. To ensure continuation of services for PLWHA and OVC, ProVIC invited all former AMITIE partners to attend a workshop to help them develop new proposals and budgets for a period of bridge funding. The ProVIC team established targets and expected results with each of the five NGO grantees (ECC, AMO Congo, World Vision, Fondation Femme Plus, and BDOM CODILUSI) based on the PMEP indicators and the authorized budget. This amounted to 4,331 PLWHA and 6,110 OVC in the project sites in Bas Congo, Katanga, and Sud-Kivu. The care and support team regularly supervised the implementation of grantee activities, based on their respective proposals, to track progress.

Needs Assessment. The ProVIC team conducted a needs assessment to explore the availability of existing care and support services and information in Bas Congo, Katanga, and Sud-Kivu (the data analysis for Kinshasa was not conducted).

The quantitative data collected focused on the number of PLWHA and OVC registered, types of services available to them, number of beneficiaries per service type offered, and information on the local partners who provide these services. Qualitative information was obtained through focus group discussions and individual interviews through different parts of the population: PLWHA, OVC, community members, implementing partners, and staff from PNMLS, PNLS, and DIVAS (Division des Affaires Sociales). These discussions/interviews allowed us to explore the actual needs of PLWHA and OVC and local, everyday realities and to solicit suggestions concerning the services ProVIC is intending to deliver. The triangulation of responses demonstrated often divergent points of view, especially in the area of stigma and discrimination at the family level and within the health systems. It also highlighted the importance, or not, of home-based care and individual versus collective income-generating activities.

Recommendations included the following:

- Greater involvement of PLWHA in the planning process, as they are in the best position to know and make decisions about activities that will benefit them, and as they wish to be fully involved at different levels (from planning to implementation).
- Training for family members to increase their skills in home-based care.
- Legal assistance and the dissemination of the laws protecting PLWHA and OVC was strongly encouraged.
- Medical support, including medical assessments/clinical check-ups, remains a crucial issue for PLWHA.
- Educational support of OVC as a key priority.
- Nutritional support in the short term, combined with agricultural support to ensure sustainability in the long term.
- Implementation of an effective continuum of care linking the individual, households, community, and health systems.

These recommendations have been taken into account during planning for Year 2.
Design of a new PLWHA care and support package and a needs-based, comprehensive OVC package. Design of the care and support package started with an evaluation of best practices and lessons learned from the CRS/AMITIE project in order to further inform development of the package. In addition, focus groups and individual interviews were conducted with PLWHA, OVC, PNLS, PNMLS, MINAS, and community members. The goal was to increase the understanding of the needs of PLWHA and OVC, the degree of community involvement, and the challenges of stigma. Meetings also took place with the national authorities and the relevant government structures in order to review the existing care and support mechanisms and to identify gaps. On the basis of this analysis, ProVIC, with the support of CRS, finalized the integrated care and support package.

The aim of the integrated package was to engage the whole family of PLWHA and OVC in implementation of actions to mitigate the impact of HIV/AIDS. The package was also designed to address the challenges linked to the care and support of PLWHA and OVC, such as psychosocial support; nutritional support; economic support; social and legal protection; palliative care, including home based care; pain management; referral to health services; vocational education; and biomedical waste management. The package was developed in accordance with national norms and policies.

Development of a positive living strategy. The design of the positive living strategy, a guide on positive living, and the associated IEC materials was managed through consultancy with UCOP+. The draft strategy and guide for positive living was tested through a series of workshops, facilitated by UCOP+ in collaboration with the ProVIC care and support team, the community mobilization officer, and RNOAC. These workshops helped to build the capacity of the networks of PLWHA on positive living, through in-depth discussions on life perceptions, attitudes, and behaviors of PLWHA. In practice, PLWHA who participated in the training sessions were able to contribute to refining of the positive living concept and to reflect on the factors that could facilitate improvements in the lives of PLWHA as well as identify individual and collective challenges they faced.

Improved links between community and clinic based care. Two consultants were recruited by IHAA to adapt the model of community engagement to the DRC context. This was done in conjunction with the health systems strengthening component. The aim of the model was to explore mechanisms for improving the links between the community and clinical and health care centers. The adapted model will be finalized and rolled out during the Year 2. It will be mostly utilized in champion communities to consolidate relationships between communities and health structures.

Supporting activity implementation at provincial level in Katanga, Bas-Congo, and Sud Kivu. The care and support activities were regularly monitored at the provincial level by the care and support specialists based in ProVIC's three regional offices. In general the care and support activities implemented at the provincial level by partners receiving bridge funding focused on the following:

- Income-generating activities.
- Distribution of information about the legal rights of PLWHA.
- Referral and counter-referral for TB testing.
- Positive living guides.
- Medical supplies and nutritional and hygiene kits.

SUCCESS STORY

Income-generating activities offer hope and opportunities to orphans and vulnerable children

Photo: Jean-Claude Kiluba (ProVIC staff).

Marie at work in her seamstress shop, established with support from local partner AMO-Congo through a ProVIC grant dedicated to fostering income-generating activities.

"Without the help of Amo-Congo (ProVIC/USAID), life would be a nightmare for me and my siblings. I would rather not have been born than have to face the hell on earth that followed after the premature death of my two beloved parents."

~ Marie Mulongoy

Marie Mulongoy, 17, lives in a poor Lubumbashi neighborhood called Kabula Menshi. Both of her parents died from HIV/AIDS when she was 15, leaving her to care for her four younger siblings.

Without money for school since their parents fell ill, all five children had been malnourished and seemed to face a hopeless future—that is, until Marie became one of the first ProVIC beneficiaries, under a grant with AMO-Congo, to receive professional seamstress training. Along with her training, Marie received a start-up kit that included a sewing machine, scissors, iron, and workbench.

Described by her instructors as "agile, dedicated, and hard working," Marie recognizes this grant as her chance at a new life and future for both herself and siblings. Since her training, she has opened a seamstress shop in her densely populated neighborhood with AMO-Congo's support. And within a few short months of starting her modest operation, Marie had already generated enough revenue to buy a second, and then a third, sewing machine, and has hired and trained two assistants.

Now all four of Marie's siblings are adequately fed and clothed and eagerly attend school. Marie is just one of AMO-Congo's 200 beneficiaries who received support through a ProVIC grant dedicated to income-generating activities.

In its first year, ProVIC has issued numerous other grants to encourage sustainable, self-help assistance for people living with AIDS and orphans and vulnerable children, empowering beneficiaries by offering targeting trainings in business management, SILC (savings and internal lending) methodology, and vocational skills such as hairdressing, public transport activities, and construction). Many of these beneficiaries have a success story like Marie's to tell.

ECC SANRU and AMO Congo ProVIC Activities in Bas Congo

- Identification of 300 new OVC and 95 PLWHA for enrolment in program activities.
- 3,646 psychosocial support visits conducted by community social workers and volunteers to 12,60 PLWHA and their families.
- Educational support for 619 OVC for "classic" training and 100 for "professional" training.
- Clinical health care to 286 adults and children.
- Income-generating activity support to 130 PLWHA/OVC and their families.
- Nutritional support to 200 adults and children.
- Legal aid to 4 PLWHA regarding stigma.
- Distribution of 3,117 positive living guides to PLWHA.
- Distribution of UCOP+ communication materials on the law protecting PLWHA and OVC.
- Supervision visits to increase and improve quality of services.

In addition, the regional care and support staff participated in the capacity building of prospective grantees by coaching them on the proposal development process and providing guidance on ProVIC's technical approach for care and support activities. They also conducted a number of activities to reinforce initiatives led by the Kinshasa-based team, such as presenting the positive living strategy by UCOP+ to local stakeholders, conducting awareness-raising workshops on the laws protecting PLWHA, facilitating province-level meetings on care and support, collaborating with the M&E team to develop a database for OVC and PLWHA, and supporting the development of the provincial OVC plan.

Problems encountered and proposed solutions

- The withdrawal of CRS from the consortium came as a shock, and PATH and the ProVIC consortium had to work swiftly to identify an alternative to CRS for the Care and Support component. We considered many options, and after careful consideration and analysis, we concluded that the International HIV/AIDS Alliance would be a strong choice for this work. This proposed solution was approved by USAID, and IHAA has effectively managed this transition, with the support of the ProVIC team.
- As with other components, both the slow process of negotiating the bridge grants and identifying new partners meant that the period for possible activities was limited. This is being addressed in the current final partner selection process.
- There were difficulties in establishing effective referral and counter-referral services for TB. This is being addressed through some of the mapping activities and development of referral guides in Year 2.
- There were challenges in working with former CRS partner World Vision as their mode of operation did not fit well with the project's bridge granting process.
- The implementation of the first year activities also demonstrated that the definition of OVC needed further clarification, as there was an inclination for some partners to enrol all orphans that they came into contact with, without referring to the PEPFAR guidelines/criteria. This will be clarified with partners this year.
- The absence of an effective targeting of OVC increased the number of OVC to be supported and reduced the quality of that support. A debate on the content/materials used

took priority over the discussion about the sustainability of the support to OVC. The majority of partners focused on the "package," and waited for ProVIC to provide all the elements. Over the year the package approach was not seen to be sustainable. Not only was the cost of providing a complete package of services exorbitant, but it did not account for the fact that different children had different needs; while some needed support with schools fees, others needed nutritional kits, etc. In Year 2, issues of sustainability and more precise criteria will be put in place for the selection of OVC and for determination of what constitutes vulnerability.

- The content of the package designed by CRS for care and support was often too generic. It did not always specify the care and support activities or how to manage them so that they led to the expected results and could be measured according to the project indicators. The financial costing of activities was not finalized so that there were often large variations in costs for the same services (taking into account any expected variation between provinces). IHAA is building on the work of CRS regarding the integrated approach to care and support and is amending and expanding it in order to address issues of sustainability, relevance, and methodology.
- The feasibility and sustainability of income-generating activities needs to be discussed and clarified. Experience in the first year showed a variation in the needs at local level: In some cases income-generating activities for individuals are more appropriate. In other areas there has been a demand for group-based income-generating activities. Nonetheless, the participation of PLWHA and OVC in this area is still very limited. One solution would be to develop partnerships with microcredit institutions that would support PLWHA and OVC in a targeted manner to implement income-generating activities.
- While the project will continue to ensure the promotion of laws that provide for social and legal protection, we also need to set up an effective device for helping PLWHA deal with the legal problems that they encounter. Generally, because of their status and their weak knowledge of human rights, they do not know their options in terms of rights to health and education. Partnerships with human rights institutions and addressing these issues at community level could assist in increasing the respect of human rights.
- The analysis, after the participation in the positive living meetings, shows that many PLWHA still have very low levels of knowledge about HIV and AIDS (for example, partial knowledge of the process of infection, of protection measures, the medical aspects, the significant advances made in research and treatment, and perceptions of HIV as a divine punishment or a curse). This can result in HIV super-infection or the infection of others in the event of unprotected sexual relations. We have begun to address this concern through a workshop on positive living in Kinshasa, where we discussed the importance of sharing and investing more in improving knowledge of HIV/AIDS, management of individuals' own health in general, and their sexual health in particular.

Key activities in Year 2

- Capacity-building for PLWHA on the positive living framework and approach.
- Development and capacity-building of self-help groups of PLWHA.
- Good practice audits of resources and services by PLWHA in their communities.
- Strengthening of implementing NGO capacity to support PLWHA with positive prevention.
- Focus on inclusion of MARPs in positive living and prevention activities.

- Strengthening of palliative care skills and knowledge within self-help groups.
- Home support visits for PLWHA led by PLWHA that also include family and health professional participation.
- Nutritional and medication support according to need (e.g. cotrimoxazole and anti-parasitical provision, vitamin supplements, energy food, access to appropriate health tests etc.).
- Training of trainers for OVC child to child approach.
- Training of OVC peer educators.
- Implementation of child-to-child approach within champion communities and supportive supervision training for peer educators.
- Promotion and dissemination of the child status index tool.

Result 3: Strengthening of health systems supported

Summary of activities and accomplishments

The health systems strengthening and human capacity-building component is a cross-cutting component which provides broad support to project activities in all areas. For project results to be sustainable, the government must be engaged in their achievement. ProVIC is therefore working through the existing health system to build the capacity and sustainability of human resources and systems. This is carried out through capacity-building of provincial governments, ensuring skills transfer from the central level to the provinces, and in turn, improved coordination at that level; through reinforcing the capacity of NGOs that offer services at the community level; and through improving strategic information systems at health service centers and community structures.

Sub-IR 3.1: Capacity of provincial government health systems supported

Assessment of capacity of provincial governments completed and capacity building plan developed. At the beginning of the program, an evaluation of basic needs at intervention sites was conducted to enable the proper identification of their basic needs. Using a data collection tool and questionnaire, we worked with health centers and community structures to determine the level of existing activities and the current gaps in the offering of services. The quantitative and qualitative analysis of data from the PNLS, MINAS, PNMLS, and Ministry of Gender and Family in the four provinces of our intervention allowed us to articulate a capacity reinforcement plan in accordance with the needs in the field. This plan covers areas beyond ProVIC's intervention sites and could be used, after local appropriation and adaptation, by the provincial authorities in other areas in the provinces, and by other non-USAID intervention programs or projects.

Among our Year 1 findings is the issue that HIV/AIDS services are not well integrated in all health structures within health zones; nor are they at the community level. The coverage of services in the health zones is limited only to the structures targeted by the projects that support them. Often, HIV/AIDS services are treated as secondary and dependent on outside assistance. This is due to the instability of the local personnel and stockouts of commodities and test kits. At the level of the provincial government, the capacity to ensure coordination, monitoring and evaluation, and regular, sustained, supervision is very limited.

Among the entities that offer community services, there are as many diverse tools in use for data collection as there are implementing partners representing different, unassociated, un-

coordinated, well-meaning organizations involved in the fight against HIV/AIDS. This has greatly compromised the ability of our government partners to provide reliable and timely information in a well-structured, standardized, harmonized form. The managerial capacity in some community structures is very weak. There is also a weak and tenuous link between community and health service centers.

The identification of these needs and gaps enabled us to plan activities that respond to the demands of the community, health system, state institutions, and implementing partners. This plan will be submitted to provincial governments, and to partners, for adoption and implementation, and would serve as a framework for building and reinforcing capacity in provinces.

Improved coordination at the Ministry of Social Affairs (MINAS) at the national and provincial levels. One of the stated priorities in the National Strategic Plan of the Ministry of Social Affairs is to prepare a Monitoring and Evaluation Plan for its National Strategic Plan for OVC. This would enable all partners working in the country to address the problems of OVC and realign their data collection and reporting systems to the M&E system of the Ministry of Social Affairs.

In response to this important need, ProVIC contributed to the development of this Monitoring and Evaluation plan by organizing a national workshop in Kinsantu (Bas-Congo Province), which regrouped 20 participants representing all the different actors (partners of the Ministry of Social Affairs) involved in work with OVC in the DRC, to work on harmonizing their data collection tools with those of the Government, and establishing indicators for the national strategic plan for OVC. The workshop resulted in the production of a national framework for monitoring and evaluation, aligned with the Government's National OVC Action Plan for 2010-2014.

Following the national M&E workshop in Kinsantu, which yielded the M&E framework, ProVIC organized a second national workshop in Kinshasa, which regrouped 47 participants representing the broadest spectrum of partners of the Ministry of Social Affairs, both at the national and provincial levels, to validate the draft national monitoring and evaluation framework for OVC. After this validation exercise, ProVIC hired a consultant who is currently preparing the final document that constitutes the National M&E Plan for OVC in the DRC. This important deliverable is expected to be ready for presentation to the Government in November 2010. At that time, the M&E tools will be tested in ProVIC intervention sites before adoption at the national level.

Provincial PNLS staff trained in integrated HIV/AIDS service delivery. Following on from the needs assessment, the training curriculum for provincial PNLS staff was examined, reviewed, and validated at the national level. This was to ensure that any training provided by ProVIC was appropriate to the context of the DRC, and was subsequently integrated into the health system at both national and provincial levels.
ProVIC organized a two-day working session at its Kinshasa headquarters to update the curriculum and the contents of the training materials. Representatives from PNLS, PNMLS, MINAS, the University of Kinshasa, and other stakeholder institutions attended this review workshop. The curriculum was adapted and consolidated to meet the varying needs of different types of service providers, comprising medical doctors, nurses, pharmacists, community workers and lab technicians. The training targeted 100 people per province. Close

collaboration on this activity, with a key ProVIC USAID-funded partner, Management Sciences for Health/Strengthening Pharmaceutical Systems (MSH/SPS), produced significant cost-sharing for us, as a result of the resulting co-financing by MSH/SPS, of the expenses related to the pharmacists from the provinces who attended the workshop.

During preparatory meetings with PNLS and partners, which preceded the actual training, the training curriculum was discussed and reviewed. As a result, participants agreed to integrate the ProVIC strategies for sustainability for stakeholders into the curriculum.

For this first year, the TOT strategy was adopted and used to train 85 trainers in the four provinces (20 per province). These trainers were expected to train 160 more service providers in their respective provinces (40 beneficiaries per province). In all, 458 persons have been trained in Year 1.

Strategic partnerships leverage training funds

An impressive 85 trainers of trainers were trained in ProVIC's four provinces.

- **Bas Congo**—22 trainers: 4 medical doctors, 4 nurses, 4 laboratory technicians, 4 social service workers, and 6 pharmacists.
- **Katanga**—23 trainers: 6 medical doctors, 2 nurses, 4 laboratory technicians, 4 social workers, and 7 pharmacists.
- **Kinshasa**—21 trainers: 14 medical doctors, 3 social workers, and 4 pharmacists.
- **Sud Kivu**—19 trainers: 4 medical doctors, 4 social workers, 4 nurses, 4 laboratory technicians, and 3 pharmacists.

This was partially due to the contribution of MSH/SPS, who funded 20 trainees to include the training of pharmacists responsible for managing drugs and related commodities.

ProVIC also trained 373 service providers in partnership with MSH/SPS who supported 93 trainees involved in the management of drugs and commodities within health centers, community centers (e.g., community HCT centers), and the distribution system.

- **Bas Congo**—95 service providers: 10 medical doctors, 23 nurses, 14 laboratory technicians, 20 social workers, and 28 pharmacists.
- **Katanga**—92 service providers: 19 medical doctors, 16 nurses, 20 laboratory technicians, 14 social workers, and 23 pharmacists.
- **Kinshasa**—101 service providers: 28 medical doctors, 28 nurses, 13 laboratory technicians, 12 social workers, and 20 pharmacists.
- **Sud Kivu**—85 service providers: 14 medical doctors, 17 nurses, 16 laboratory technicians, 16 social workers, and 22 pharmacists.

Training of "champion" peer educators. In the implementation of prevention activities, the community mobilization component of ProVIC organized training for peer educators in clubs within champion communities. A total of 351 people were trained as peer educators within their respective communities to carry out awareness exercises in the fight against HIV/AIDS: 91 in the Bas-Congo, 91 in Kinshasa, 96 in Katanga, and 73 in Sud Kivu.

Sub-IR 3.2: Capacity of NGO providers improved

As part of the grants application process, potential NGO implementing partners benefitted from a training and capacity assessment process. Of the 456 concept papers received, 72 were short-listed for consideration to receive grants awards (21 from Kinshasa, 16 from Sud Kivu, 16 from Bas-Congo, and 19 from Katanga). Two people representing each of these NGOs benefitted from a ProVIC training in project cycle management in order to help them prepare better quality proposals. ProVIC also conducted evaluations of its managerial capacity to determine their capacity to manage grants and achieve results.

Sub-IR 3.3: Strategic information systems at community and facility strengthened

Harmonized M&E data collection tools provided to implementing partners. After collecting M&E tools from different partners, including PNLS, PMLS, health zones, and potential implementing partners, for harmonization, the next step was to analyze gaps and produce tools which fit with ProVIC indicators. All of these tools have been consolidated into a single document and distributed to all our implementing partners and regional offices for use as the ProVIC M&E manual. All ProVIC M&E staff worked with M&E focal points from our new implementing partners to ensure that the M&E data collection tools are properly used in our project to produce the required high-quality and credible reports.

Improved M&E coordination at the national level. PNMLS has planned to develop the M&E framework aligned with the National Strategic Plan in the fight against HIV/AIDS covering the period 2010-2014. The ProVIC M&E unit prepared and submitted a concept note to PNMLS with a view to integrating PEPFAR indicators in the national M&E framework. The ProVIC M&E specialist participated in several M&E Task Force meetings for the preparation of operational and sectoral plans that are aligned with the National Strategic Plan to fight against HIV/AIDS, and the preparation of the National AIDS Spending Assessment (NASA).

To more fully align the project M&E system with the national one, ProVIC's M&E specialist held several preliminary working sessions with the M&E officers of PNMLS to begin the design of data processing software to be used by ProVIC to this end. Furthermore, to create linkages between the program's M&E objectives and those of the partner organizations, M&E tools were collected from partners, including PNLS, PMLS, health zones, and potential implementing partners, for harmonization with the national M&E system. ProVIC worked with specific M&E counterparts in various partner institutions to vet project indicators, facilitate the exchange of pertinent baseline data, and identify synergies between the program's M&E system and those of national and regional organizations to identify the best and most efficient methods of collecting, analyzing, and exchanging data.

Model developed for linking communities with facilities. The project hired an international community engagement consultant to develop a model for improving linkages between health service facilities and communities and determine, on the one hand, the needs of service providers and implementing partners, and on the other hand, prepare an assessment of the actual relation between the community and the health centers. The consultant also evaluated the capacity of local leadership to mobilize all members of the community in planning and decision-making and the capacity of health service providers to offer at least one service and one piece of high-quality information that would encourage members of the community to engage in their own development.

By analyzing the relationship between health services and the community, we were able to ascertain opportunities upon which ProVIC could build its strategy for community engagement to provide HIV prevention and care and support services. A capacity improvement plan was developed for community organizations in order to inform, initiate, implement, and ensure the follow-up of initiatives for their development. This would help increase involvement of PLWHA in the program cycle, particularly in champion communities.

Problems encountered and proposed solutions

- Government partners lack consensus on administrative and financial procedures, particularly with regard to per diems in joint training workshops. This issue has led to some delays in starting training activities but has since been resolved through negotiations with the government and other implementing partners.
- The absence of a map of health service providers within the health zones of ProVIC's intervention sites hampers the efficient functioning of referral and counter-referral systems between services. A simple solution would be the mapping of such services within all ProVIC's intervention areas. This has been planned for Year 2.

Planned activities for Year 2

- Develop a capacity-building plan for the provincial government.
- Support MINAS to develop training materials for care and support.
- Conduct an integrated training for services providers in champion communities.
- Support joint supervision and coordination meetings with government partners.
- Support the development and implementation of evidence-based policies and guidelines.
- Identify feasible health financing options.
- Reinforce the capacity of health centers to properly manage handling and disposal of biomedical waste.
- Build the technical and managerial capacity of NGO partners.
- Train provincial actors (at the health facility and community levels) in M&E.
- Strengthen the project's quality assurance system.
- Support M&E reporting systems.
- Support M&E systems in champion communities.
- Provide support for M&E activities at the national and provincial levels to PNMLS, PNLS, and MINAS.
- Map local services at their delivery points.

SUCCESS STORY

Providers reach new clients with integrated HIV/AIDS services

Photo: Elysé Zambite (ProVIC staff).

ProVIC strengthens health systems at the community level by integrating service delivery—from HIV counseling and testing to family planning and PMTCT needs.

As a nurse at Panda Hospital in Katanga, DRC, Josephine is frequently confronted with numerous problems—among them, how to care for people living with HIV/AIDS, what services to recommend to those with HIVpositive family members, and how to care for HIV-positive pregnant women in order to prevent mother-to-child transmission.

The PEPFAR-funded USAID ProVIC project recently provided training to Josephine and 85 other health care providers in integrated HIV/AIDS service delivery. This training focused on provider-initiated counseling and testing, encouraging providers such as Josephine to speak with patients, regardless of what brought them to the hospital, about HIV/AIDS testing and care. Josephine was then able to share this knowledge with her colleagues by organizing briefings with other nurses at the hospital.

Because of her ProVIC training, Josephine can now conduct basic HIV counseling and testing and provide basic care and treatment for those infected with HIV/AIDS—including for HIV-positive pregnant women and their related PMTCT needs. She can discuss available treatment options with her patients, including sharing prevention messages and encouraging them to reach out to others in their community who might be affected and need services. Interventions like these will bolster the hospital's community outreach efforts and increase awareness of available services.

Through integrated trainings like those at Panda Hospital, ProVIC is ensuring that nurses, doctors, pharmacists, and community health workers can offer high-quality HIV/AIDS services to all their clients regardless of their work environment. Getting people tested and referred to services in this way has helped the project and the country achieve new levels of scale and will ultimately lead to a reduction in the negative impacts of HIV/AIDS on communities.

SECTION 2. OVERVIEW AND GENERAL CROSS-CUTTING ISSUES

Progress toward results: Project monitoring and evaluation

Summary of activities and achievements

ProVIC's M&E system is one which includes the regular collection and analysis of information to assess progress in the implementation of planned activities and the established performance targets, assist in timely decision-making, ensure accountability and provide the basis for evaluation and learning. ProVIC's information relies on high-quality data obtained from indicators which had been harmonized with USAID and national and sub-national counterparts. Its M&E system is critical not only to help assess progress towards the desired improvements, but also to provide feedback to stakeholders and the community at large, assess how community groups have changed as a result of project activities and identify future directions.

In the first year, much of the project activities centered primarily around two focus areas: building a strong ProVIC M&E system and improving national M&E systems. This next section describes in detail tasks undertaken to accomplish the two goals in Year 1.

Establishing ProVIC's M&E system

Reporting system developed. Much of the first quarter was spent developing the Performance Monitoring and Evaluation Plan (PMEP), Year 1 work plan, and COP. The PMEP is a practical tool, articulating the project's approach to systematically gauge the implementation process and outputs throughout the life cycle. Both the PNMLS and PNLS participated in the design of the PMEP in order to ensure that national indicators were integrated into the project's reporting system. Meeting these PMEP targets depends heavily on developing strategic collaborations with stakeholders and partners. MINAS was invited to the annual work plan workshop, where discussions were held to explore areas of collaboration and support.

In designing the COP, the Kinshasa-based M&E specialist met with the PEPFAR/CDC-DRC/SI focal point and COTR to discuss project PEPFAR targets and solicit USAID's feedback. Both the PMEP and work plan were updated and more realistic PMEP targets set in in March 2010. The work plan, in turn, was revised mid-year. With a complete staff at mid-year, ProVIC was better equipped to identify targets that could be realistically achieved in Year 1. ProVIC conducted a four-day workshop to bring together partner agencies and organizations to review project objectives and identify areas for collaboration. The discussions helped complete the project partnership framework and harmonize the project's planned activities with those of our partners.

ProVIC's data collection and reporting tools adapted. During the past year, ProVIC's data collection and reporting tools were developed based on existing tools collected from partner organizations and agencies (e.g., PNLS and PMLS). Efforts were made to harmonize ProVIC's M&E objectives along with those of its partner organizations. Ms. Ndagano worked with specific M&E counterparts to vet project indicators, facilitate exchange of pertinent need assessment data, and identify synergies between the project's M&E system and those of national and sub-national organizations. ProVIC also considered existing tools

developed by PATH and other NGOs that were previously involved in ProVIC's predecessor project. ProVIC's tools were largely validated in September, when the DC-based M&E specialist visited the DRC. Furthermore, other M&E tools obtained from the MEASURE Evaluation workshop in South Africa by the Kinshasa-based M&E specialist will be considered and used as appropriate.

ProVIC M&E team completed. Denise Ndagano, the Kinshasa-based M&E specialist, was recruited in January 2010. Her job is to coordinate monthly, quarterly and annual data collection and analysis of project-generated data, support national M&E systems, supervise regional M&E specialists, and oversee the M&E system in the Kinshasa province. In June, the regional M&E specialists, Antoine Mafwila, Enoch Nzau, and Venant Zihalirwa, joined the project based in the Lubumbashi, Matadi, and Bukavu, respectively. They are responsible for coordinating data collection and reporting on their respective provinces. A DC-based M&E specialist, Anh Thu Hoang, completes the M&E team by providing direct technical support and supervision to the Kinshasa-based M&E specialist, conducting internal audits, and providing ad hoc M&E trainings to the M&E team as part of her ongoing supervision of M&E field work.

Ongoing training to ProVIC team. Denise Ndagano conducted an orientation for the three regional M&E specialists in July 2010. The purpose of this orientation was to provide basic ProVIC project information and ProVIC M&E-specific information to the regional M&E specialists. The team also discussed PEPFAR indicators and other reporting obligations. The hands-on workshop provided an opportunity for the M&E team to develop the project's own reporting tools for each component (e.g., PMTCT, HCT, care and support). ProVIC also benefitted from CRS' M&E specialist, who visited the DRC as STTA; this specialist briefly oriented the team to CRS' M&E approach and Simple Measurement of Indicators for Learning and Evidence-based Reports (SMILER). SMILER links objectives and their indicators to a system for collecting, analyzing, and reporting on data. It also includes mechanisms to translate data into useful knowledge that supports sound project decision-making. While ProVIC does not adhere to any single M&E approach, the CRS approach produced a useful set of tools for the M&E team to add to its toolbox.

Ms. Hoang provided technical support to ProVIC's M&E team in September 2010. Their joint work over a two-week period consisted of examining ProVIC's M&E system, collaborating with MINAS, and exploring potential areas of collaboration in PMTCT research with MEASURE Evaluation. Ms. Hoang assessed ProVIC's M&E needs at the national and regional levels, leading team discussions about double counting and data quality. She also worked with the team to re-examine data collection and reporting tools, discussing applications in the field as well as PEPFAR indicators that had been revealed as problematic for the team. Table 5 on the following page summarizes Year 1 results against these PEPFAR indicators and initial targets.

Table 5. Year 1 ProVIC results against PEPFAR indicators and targets

PEPFAR Indicator	Targets	Achievements					Remarks
		Quarters 1 & 2	Quarter 3	Quarter 4	Year 1 Total	Year 1 % Achievement	
1. Prevention of mother-to-child transmission (PMTCT)							
P1.1D **Number** of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	11500		687	6174	6861	59.7%	Weak results observed due to delays in providing support to PMTCT sites during start-up, and in obtaining pharmaceuticals for PMTCT and pediatric care.
Known positives at entry	41		1	18	19	46.3%	This target was over estimated: fewer women than expected know their HIV status at entry.
Number of new positives identified	177		15	121	136	76.8%	
P1.2D **Number** of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child transmission	130		12	87	99	76.2%	
P1.2D **Number** of known HIV-positive pregnant women	218		16	139	155	71.1%	Weak result observed due to delays in providing support to PMTCT sites during start-up, and in obtaining pharmaceuticals for PMTCT and pediatric care.
By prophylactic regimens: Single-dose Nevirapine only			12	79	91		We are currently working with partners to disaggregate reported data.
By prophylactic regimens: Prophylactic regimens using a combination of 2 ARVs			0	0	0		
By prophylactic regimens: Prophylactic Regimens of 3 ARVs			0	4	4		
By prophylactic regimens: ART			0	5	5		
2. Sexual prevention/abstinence and being faithful (HVAB)							
P8.2D **Number** of the targeted population reached with individual and/or small group-level preventive interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	2242		20	8891	8911	397.5%	There are 357 peer educators: 91 in Bas Congo; 94 in Kinshasa, and 74 in Sud Kivu. 1 small group communication was conducted per month, with each group averaging 25 people.
3. Sexual prevention/other sexual prevention (HVOP)							
P8.1D **Number** of the targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	345000		31004	285298	316302	91.7%	
P8.3D **Number** of MARP reached with individual and/or small group level interventions that are based on evidence and/or meet the minimum standards	28500		4597	26573	31170	109.4%	Increased results due to intensified targeted activities during Q4.
By MARP type: CSW, IDU, MSM							
CSW	8550		403	3689	4092	47.9%	CSWs are very mobile, hard to track, and generally covert. <75% of achievement reflects the challenges we faced in targeting them. The main reason for this shortfall, however, is that these activities did not begin during the project's 6-month start-up period.
Truckers	8550		3108	13551	16659	194.8%	MOU with truckers' associations were signed, and synergies between PSI and our partners in the field substantially improved Year 1 results.

PEPFAR Indicator	Targets	Achievements					Remarks
		Quarters 1 & 2	Quarter 3	Quarter 4	Year 1 Total	Year 1 % Achievement	
3. Sexual prevention/other sexual prevention (HVOP)							
By MARP type: CSW, IDU, MSM							
Fishermen	7150		202	3408	3610	50.5%	Although many efforts were made to reach fishermen, their high mobility and irregular work cycles resulted in missed opportunities to reach them; teams arrived at locations only to find that fishermen had changed their schedules or that they had not returned to their villages from fishing trips. Furthermore, activities were only begun in Q3 after bridge grants were awarded.
Miners	5700		420	5533	5953	104.4%	
MSM	570		0	392	392	68.8%	Weak results observed due to the particularity of this hard-to-reach MARP; however, our partnership with PSSP helped ProVIC improve its targets during Q4.
4. Biomedical prevention/blood Safety (HMBL)							
5. Biomedical prevention/injection safety (HMIN)							
6. Biomedical prevention/injecting and non-injecting drug use (IDUP)							
7. Biomedical prevention/male circumcision (CIRC)							
8. Care and support							
C1.1D **Number** of eligible adults and children provided with a minimum of one care service	18500	2483	9127	7914	19524	105.5%	
By Age: <18,	6166	1722	5489	5407	12618	204.6%	
By Age: 18 +	12334	761	3638	2507	6906	56.0%	
By sex: Male	8140	598	3948	3793	8339	102.4%	
By sex: Female	10360	1885	5179	4121	11185	108.0%	
9. Adult care and support (HBHC)							
10. Pediatric care and support (PDCS)							
C4.1D **Percent** of infants born to HIV-positive women who received an HIV test within 12 months of birth	0.05		0%	13%	11.6%	232.3%	ProVIC's intensified tracking system includes identifying HIV-positive pregnant women, their children, and fathers. Phone calls are made and followed by home visits if mothers do not then show up with their children for early diagnosis and testing.
Numerator: Number of infants who received an HIV test within 12 months of birth during the reporting period			0	18	18		
Infants who received virological testing in the first 2 months			0	2	2		
Infant who were tested virologically for the first time between 2 and 12 months or who had antibody test between 9 and 12 months			0	16	16		
Denominator: Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positives at entry)			16	139	155		

PEPFAR Indicator	Targets	Achievements					Remarks
		Quarters 1 & 2	Quarter 3	Quarter 4	Year 1 Total	Year 1 % Achievement	
10. Pediatric care and support (PDCS)							
C4.2D **Percent** of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth	0.2		0.0%	1.4%	1.3%	6.5%	<75% of achievement is due to lack of commodities.
Numerator: Number of infants born to HIV-positive pregnant women who are started on CTX prophylaxis within two months of birth			0	2	2		
Denominator: Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positives at entry)			16	139	155		
Treatment							
11. Adult treatment (HTXS)							
12. Pediatric treatment (PDTX)							
13. TB/HIV (HVTB)							
C2.4D TB/HIV: **Percent** of HIV-positive patients who were screened for TB in HIV care or treatment settings	0.7		8.1%	69.5%	60.6%	86.6%	Note that ProVIC does not provide TB testing, only referrals.
Numerator: Number of HIV-positive patients who were screened for TB in HIV care or treatment settings			36	1837	1873		
Denominator: Number of HIV-positive adults and children receiving a minimum of one clinical service			446	2643	3089		
C2.5D TB/HIV: **Percent** of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	0.08		6.1%	10.5%	9.8%	123.0%	High results observed due to active involvement of PLWHA networks (UCOP, RNOUAC).
Numerator: Number of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment in HIV care or treatment (pre-ART or ART) who started TB treatment			27	277	304		
Denominator: Number of HIV-positive adults and children receiving a minimum of one clinical service			446	2643	3089		
14. Orphans and vulnerable children (HKID)							
C5.1D **Number** of eligible clients who received food and/or other nutrition services	10600		763	542	1305	12.3%	Weak achievement for Year 1 was mainly due to the original target having been set too high (this has been rectified for Years 2 and 3), and to activities taking off only until after the first 6-month 'start-up phase' of the project. Withdrawal of CRS, who led this component, further impacted activities in Q3 and Q4. Scale-up will occur once new grants are issued (in Q1 of Y2).
By Age: <18,			264	426	690		
By Age: 18+			499	116	615		
Pregnant			0	0	0		
Lactating women			0	0	0		

PEPFAR Indicator	Targets	Achievements					Remarks
		Quarters 1 & 2	Quarter 3	Quarter 4	Year 1 Total	Year 1 % Achievement	
15. Counseling and testing (HVCT)							
P11.1D **Number** of individuals who received testing and counseling (T&C) services for HIV and received their test results	144700	8216	13757	55963	77936	53.9%	<75% achievement is due to lack of commodities until mid-Q3. With test kits in hand, results rose steeply in Q4.
By sex: Male and	73797	4327	7523	31176	43026	58.3%	
Female	70903	3869	6234	24787	34890	49.2%	
By age: <15 and		281	439	5762	6482		
15+		7935	13318	50201	71454		
By test result: Positive	5788	591	840	1533	2964	51.2%	
By test result: Negative	138912	7625	12917	54430	74972	54.0%	
16. ARV drugs (HTXD)							
T1.1D **Number** of adults and children with advanced HIV infection newly enrolled on ART	500		0	0	0	0.0%	ProVIC does not provide ARVs (except for HIV-positive pregnant women), and to date we have not tracked individuals enrolled following ProVIC referral.
By sex: Male	220		0	0	0	0.0%	
Female	280		0	0	0	0.0%	
By age: <1			0	0			
<15			0	0			
15+			0	0			
Pregnant women			0	0			
T1.2D **Number** of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	450		0	0	0	0.0%	ProVIC does not provide ARVs (except to HIV-positive pregnant women), and to date we have not tracked individuals enrolled following ProVIC referral.
By sex and age: Male < 15 yrs			0	0			
Female < 15 yrs			0	0			
Male : 15+ yrs			0	0			
Female: 15+ yrs			0	0			
< 1yr			0	0			
T1.3D **Percent** of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	N/A		0	0	0	N/A	
17. Laboratory infrastructure (HLAB)							
18. Strategic information (HVSI)							
19. Health systems strengthening (OHSS)							
H2.3D **Number** of health care workers who successfully completed an in-service training program	400		211	247	458	114.5%	ProVIC trained 458 individuals, 113 of whom were financially supported by the SPS project.
By specific types (e.g., male circumcision, pediatric treatment, integrated training)							

PEPFAR Indicator		Targets	Achievements					Remarks
			Quarters 1 & 2	Quarter 3	Quarter 4	Year 1 Total	Year 1 % Achievement	
20. Management and staffing (HVMS)								
21. Other indicators (guidance on how to determine which budget code to assign to these indicators is forthcoming)								
P7.1D **Number** of people living with HIV/AIDS (PLWHA) reached with a minimum package of prevention with PLWHA interventions		8600		500	1345	1845	21.5%	Please refer to explanation provided for Indicator C5.1D.
C2.1D **Number** of HIV-positive adults and children receiving a minimum of one clinical service		18500		446	2643	3089	16.7%	Please refer to explanation provided for Indicator C5.1D.
	By age: <15			186	472	658		
	By age: 15 +			260	2171	2431		
	By sex: Male			276	837	1113		
	Female			170	1786	1956		
C2.2D **Number** of HIV-positive persons receiving cotrimoxazole prophylaxis		8600		138	1414	1552	18.0%	<75% due to lack of commodities. While we were able to successfully leverage partner resources for the provision of some cotrimoxazole, ProVIC did not receive USAID approval to purchase this drug until September 2010.
	By age: <15			42	224	266		
	By age: 15+			96	1190	1286		
C2.3D. **Number** of HIV-positive clinically malnourished clients who received therapeutic or supplementary food		1850		767	18	785	42.4%	Please refer to explanation provided for Indicator C5.1D.
C3.1D. **Percentage** of TB patients who had an HIV test result recorded in the TB register		0.6		28.1%	21.1%	24.6%	41.0%	Please refer to explanation provided for Indicator C2.4D. ProVIC will work to improve its reporting and tracking mechanism with partners to capture this information.
C5.7.D. **Number** of eligible adults and children provided with economic-strengthening services		2100		313	208	521	24.8%	Please refer to explanation provided for Indicator C5.1D.
	By Age: <18,			94	154	248		
	By Age: 18+			219	54	273		
C5.3.D. **Number** of eligible children provided with health care referral		3700		540	111	651	17.6%	Please refer to explanation provided for Indicator C5.1D.
C5.4.D. **Number** of eligible children provided with educational and/or vocational training		3700		2213	1083	3296	89.1%	
C5.6.D. **Number** of eligible adults and children provided with psychological, social or spiritual support		9250		2723	6589	9312	100.7%	Positive results observed is due to active involvement of PLWHA networks (UCOP, RNOUAC).
	By Age: <18			1559	5375	6934		
	By Age: 18+			1164	1214	2378		
C5.5.D. **Number** of eligible adults and children provided with protection and legal aid services		19		1	5	6	31.6%	Please refer to explanation provided for Indicator C5.1D.
	By Age: <18			0	0	0		
	By Age: 18+			1	5	6		

Needs assessments completed. In order to design effective program strategies and better serve project beneficiaries, needs assessments were conducted in the four ProVIC provinces. Between January and March 2010, program technical coordinators, along with the Kinshasa-based M&E specialist, conducted needs assessments in Kinshasa, Bas Congo, Katanga, and Sud Kivu to gather administrative data from existing health facilities. Focus group discussions and in-depth interviews were also conducted with men, women, OVC, PLWHA, and service providers to obtain their perspectives on HIV/AIDS-related services and stigma issues. Both quantitative and qualitative methods were used to triangulate results.

This exercise also enabled the project to determine the management capacities available in intermediary structures (e.g., provinces and districts) in terms of supervisory staff, and health care providers in health zones in terms of planning, monitoring, supervision, and coordination of integrated activities pertaining to HIV/AIDS control. It also identified partners and types of interventions needed to establish synergies among HIV/AIDS activities in a given health zone. These findings helped inform revisions to the work plan and PMEP in March 2010. Moreover, they revealed not only gaps where more reliable data is needed to identify the project's sites and estimate targets, but also highlighted areas where integrated services may be most effective. A report summarizing these findings was submitted to USAID in May 2010.

Supporting national M&E systems

Involvement of stakeholders and building synergies. In order to capitalize on existing resources, the project team, led by the Chief of Party and Deputy Chief of Party and technical coordinators, have been working with key national and provincial stakeholders, including PNLS, PNMLS, PNSR (the Ministry of Health National Reproductive Health Program), PNT (the Ministry of Health National Tuberculosis Program), PRONANUT (the Ministry of Health National Nutrition Program), health zones, and implementing partners, to keep them abreast of ProVIC's goal, objectives, and strategies, as well as discuss areas of collaboration.

In its first year, ProVIC has focused on providing support to both PNMLS and MINAS. ProVIC has been supporting PNMLS in its work to develop a new Monitoring and Evaluation Framework reflecting PEPFAR's information needs. This work is anticipated to be completed in the first quarter of Year 2. ProVIC's involvement with and support to MINAS during this year has included developing a set of national OVC tools so that partners at all levels could track and report on common indicators. This work was achieved by a consultant hired by MINAS who organized a national workshop, bringing national and provincial representatives of partner organizations and national agencies to harmonize and develop these tools. A coordination meeting in the last quarter of Year 1 validated the OVC tools developed.

Coordination and support to implementing partners (IPs)

In addition, ProVIC provides monthly monitoring visits to partner organizations in the four provinces. Conducting routine visits to service delivery sites is essential to troubleshooting, as successes and issues are identified as early as possible to facilitate timely adjustments. The four M&E specialists began routine IP health service delivery site visits during the last quarter of Year 1. Following initial visits, the ProVIC team realized that standardized monitoring checklists are needed for the team to provide consistent supervision across project sites in the four provinces. The M&E team is developing monitoring checklists for each program component.

Problems encountered and proposed solutions

The following challenges were encountered during Year 1:

- Since ProVIC did not have an M&E specialist in the project start-up phase, the PMEP was developed by a consultant and selected newly-hired ProVIC staff. Consequently, some Year 1 targets proposed were not realistic given the country context, implementation challenges, and project resources. While Year 1 targets were updated in March 2010, Year 2 targets still need to be revised to apply the knowledge and experiences acquired during Year 1.
- The needs assessment in Kinshasa revealed that much of the PMTCT data was missing at the PNLS provincial level. Some data were not desegregated, which made analysis difficult for some sites. Data collection tools also differed across facilities and health zones, making the data comparisons a challenge. ProVIC has been working with these entities to build their data collection capacity throughout the course of the project.
- Recruitment of M&E staff at the regional level was challenging due to salary caps found in the contracts for these positions. The salary range for regional M&E officers was underestimated in the proposal budget, and identifying qualified personnel to fill these positions under the salary caps proved impossible. We discussed this with USAID's CO and COTR and plan to request a contract modification to revise these salary caps to reflect an appropriate rate for such qualified candidates.

The following are some anticipated activities for Year 2:

- The Washington, DC-based M&E specialist will provide an orientation on quality assurance methods to the M&E team.
- A quality assurance system (i.e., internal audits) will be implemented.
- SanteNet's tools will be adapted for use in champion communities.
- ProVIC tools will be revised to reflect national data needs (particularly new WHO guidelines on ARV) and the integration of TB, gender, and FP components with the provision of integrated HIV/AIDS services.
- The ProVIC M&E team will provide M&E training to implementing partners on the ProVIC M&E system, data collection and reporting tools, definition of PEPFAR indicators, and related M&E issues.
- We will continue to support MINAS to pilot the OVC tools in two of ProVIC's provinces, as well as finalize these tools.
- We will support PNMLS in conducting a national AIDS spending assessment (NASA) with project partners. [2] NASA provides indicators on the financial country response to AIDS and supports the monitoring of resource mobilization.

Grants management

Summary of activities and achievements

ProVIC conducted a five-day workshop in December 2009 to introduce organizations that had previously received funding from Family Health International (FHI) and Catholic Relief Services (CRS) to the ProVIC grants project, and to establish continuation grants. Participant

[2] The NASA is a tool to install a continuous financial information system within the national monitoring and evaluation framework. Other uses include monitoring the implementation of the National Strategic Plan and advances towards completion of internationally or nationally adopted goals such as universal access to treatment or care.

organizations (listed below) included representatives from HCT centers that had been supported by FHI under the USAID-funded predecessor project, as well as select PLWHA and OVC beneficiaries that had been supported by CRS under the same predecessor project.

- Corporate Committee for Local Development (CCLD) Midema—Matadi
- BDOM Codilusi—Lubumbashi
- World Production—Lubumbashi
- AMO-CONGO—Kinshasa, Lubumbashi (Kasumbalesa), Matadi
- HGR Kenya—Lubumbashi
- HGR Nyatende—Lubumbashi
- HGR Kiamvu—Matadi
- Centre de Sante Mvuzi—Matadi
- World Vision International in DRC—Bukavu, Kinshasa, Lubumbashi
- HGR Panda—Lubumbashi (Likasi)
- Femme Plus—Bukavu, Kinshasa
- Eglise du Christ au Congo/Sante en milieu Rural (ECC/SANRU) – Matadi

Photo: Francis Ntumba (ProVIC staff).

Following this process, ProVIC concluded bridge grant agreements with six of these organizations:

- BDOM Codilusi
- World Production
- AMO-CONGO
- ECC/SAANRU
- Femme Plus
- World Vision

Further, beyond these formal grant agreements ProVIC undertook a strategy of direct in-kind procurement of various government hospitals' *General de Reference* (HGR) and *Centre de Sante de Reference* (CSR). While ProVIC had intended to conclude grant agreements with all of the former grantees of FHI and CRS, ProVIC chose to pursue a strategy of direct assistance with these groups in order to better manage spending among those organizations with limited financial and administrative capacity. While this was a time-consuming strategy, memoranda of understanding were eventually secured with the following hospitals and health centers:

- HGR Kiamvu
- CSR Mvuzi
- HGR Kenya
- HGR Panda
- HGR Nyatende

All agreements were concluded for an initial three-month period while a strategy was envisioned that would continue support to these existing grantees, during which time a request for applications (RFA) would be launched—allowing them, as well as new organizations, to seek further funding.

ProVIC launched its first RFA/program statement to solicit grant applications on April 5, 2010. The response was substantial, with over 450 concept papers received for review. Among the concept papers received, ProVIC invited 73 organizations to attend workshops

designed to help each organization complete and submit a formal grant application. By the end of these workshops, 71 one-year grant applications were submitted (17 from Bukavu, 19 from Lubumbashi, 21 from Kinshasa, and 14 from Matadi). Following careful deliberations, including financial and administrative capacity risk assessments, ProVIC selected 20 groups to submit formal grant applications.

In several cases where the proposed grantee was a new partner unaccustomed to working under a USAID contract, applicants were asked to refine their applications, from a one-year grant (or MOU for direct assistance) to a shorter term of three to four months, with specific and achievable targets. This shorter term period was designed to allow ProVIC a period to further evaluate the capacity of certain groups to successfully implement activities in a fiscally responsible manner, thus mitigating risks to PATH and USAID. It was noted that the majority of grant applications presented inflated budgets that did not reflect those of projects seeking simply to support and increase existing activities. Again, the shorter grant period would allow ProVIC to provide close supervision and work with these groups to further refine a longer-term agreement, where appropriate.

Following presentation of these 20 applications to USAID for approval, we concluded during our evaluation that the initially proposed number of grantees and short-term grant period was not ideal. Instead, it was advised, securing fewer grantees would yield an overall greater impact over a longer period. Furthermore, the Champion Community strategy was not integrated into grant applications, and ProVIC needed to more strongly underscore with prospective partners the importance of incorporating this strategy into proposed activities.

ProVIC has since reduced the number of prospective grantees to 14 and is currently orienting them to the Champion Community approach. We expect to receive their revised proposals shortly and anticipate that their activities will be launched during the first quarter of Year 2, pending USAID approval.

In the meantime, in order to accelerate activities with a view to achieving Year 2 targets, ProVIC has also pursued short-term direct assistance strategies with other HGRs and a couple of local NGOs. This strategy targets specific intervention areas, particularly care and support and PMTCT activities, with organizations that have demonstrated both implementation capacity and their ability to achieve results quickly.

Problems encountered and proposed solutions

- As noted in previous reports, managing expectations among the existing partners was a significant challenge. Although bridge grants are used to expedite issuing funding to pre-selected partners, they are still subjected to a rigorous review and approval process that partners and staff may not have anticipated. This was further compounded by the fact that budgets submitted by partners were inflated and significantly higher than the funding they had received to date. Several weeks were spent negotiating budgets down and realigning expectations that these bridge grants were to ensure the continuation, and not expansion, of activities that had been funded by AMITIE. This was particularly evident among HGRs and precipitated ProVIC's decision to purse a direct assistance strategy. Eventually, ProVIC established realistic budgets with these partners to move activities forward, but the perception was that these were significantly delayed.
- The RFA process raised expectations among the 71 groups selected for grants preparation training. ProVIC asked groups to refine their applications several times before the final selection of 20 groups were presented for approval. These continual revisions and changes further raised expectations, and those who were eventually informed that their

applications would not be approved faced great disappointment. In hindsight, we should have been clearer with potential grantees that an invitation to prepare an application was not a guarantee of future funding. This message was communicated, but perhaps not strongly enough, as expectations were nonetheless high, and for some, unmet.

- ProVIC's evolving strategy for grants implementation and direct funding activities was challenging to both partners and staff. In effort to achieve results based on the very ambitious targets that had been set for Year 1, ProVIC occasionally rapidly implemented activities that were not fully coordinated with our overarching strategy. While these activities did produce results, the effort was often stressful. During our work planning for Year 2, we gave considerable thought to improving this, and we are confident that our Year 2 grants and direct funding activities will be conducted in an environment that will allow adequate time for coordinated implementation.
- Recruitment of a grants manager in Kinshasa was challenging due to the maximum daily rates found in the contract for this position. The salary range for this position was underestimated in the proposal budget, and identifying qualified personnel to fill this position proved very difficult. This caused significant recruitment delays, which may, however, been a blessing in disguise. Indeed, given USAID's recent guidance to consider awarding fewer grants, and limiting the number of grantees to approximately 10 to 12 organizations, we believe that the current pool of grants managers (comprised of a full-time grants manager based in Lubumbashi, a full-time grants manager based in Bukavu, a part-time grants manager based in Matadi, and a grants accountant based in Kinshasa) should suffice to successfully manage the grants and direct assistance portfolio. We have therefore postponed this recruit until we can firmly establish the need for an additional person in this role.

Anticipated activities and plans for Year 2

- Submit up to 14 new grants for approval during the first quarter and roll these out.
- Continue to finance HGRs and CRS though our system of direct financing.
- Regular monitoring and capacity building of implementing organizations provided by the grants managers, in collaboration with the technical staff as appropriate (w.g., regional M&E specialists and community mobilization specialists).

Administration and finance

Summary of activities and achievements

Administration

During Year 1, the ProVIC team successfully set up its main office in Kinshasa and satellite project offices in Bukavu, Lubumbashi, and Matadi. Each office is completely and legally registered within the provinces in which they operate. All offices are fully functioning and fully staffed, and the regional offices integrate and coordinate their activities with the main office in Kinshasa. In addition, all are fully furnished and equipped with internet and computer network systems.

Finally, all offices have completed an emergency action plan. The first version of the ProVIC Policy Manual has been reviewed in the field office by the COP, with inputs from the administrative and finance specialist. We now await its final review, validation, and adoption by all Consortium members before it is officially implemented in our field offices. The project has also procured six new vehicles during the year, which have been deployed as follows: three for the Kinshasa office and one for each of the regional offices. In all

provincial offices, vehicle allocation is as follows: four in Kinshasa (central and provincial offices, combined), two in Bas Congo, three in Katanga, and three in Sud Kivu.

Finance

Since project start-up, the finance and administrative specialist, together with the local team, has been working to establish strong financial management procedures that ensure compliance with USAID regulations, transparency, and accountability in the use of program funds.

All ProVIC offices have bank accounts, with the main Kinshasa office providing funds to satellite offices through wire transfers. All ProVIC accountants and office managers received training from a Chemonics International field accounting specialist in the use of financial accounting software, and in the required practices for accounting for project funds.

Currently all offices are using the ABACUS accounting software, which allows offices in both Kinshasa and Washington to review transactions online in real time. To support financial activities in the field, the finance and administrative specialist conducts supervisory visits to each satellite office.

Recruitment

During the first part of the year, the ProVIC team liaised with a local labor lawyer to help draft ProVICs employment agreement template in accordance with local labor law. Employment agreements and benefits packages were used to hire local staff for each project office. As of March 2010, the project has been fully staffed, with complete teams working in all four regions. Most recently, regional monitoring and evaluation specialists took their posts in the satellite offices. As project vehicles have cleared customs, moreover, additional drivers were hired in Bukavu and Lubumbashi. The grants accountant began working at the Kinshasa office in July.

Procurement

The project has an $800,000 procurement budget under the Strategic Activities Fund (SAF) for the purchase of commodities to implement HCT and care and support activities. When this budget was conceived, it was understood that a basic level of services and associated commodities, were available through either public sector facilities or faith-based facilities and that the project's role would be focused on improving those services through technical assistance and capacity building; linking communities to services and creating demand through the Champion Community approach; and improving quality. It has since become clear however that the targeted project sites depend completely on external support to offer services. For example, hospitals targeted for HCT cannot do HCT if they are not provided with all the inputs including gloves, test tubes, pipes, etc. This was not foreseen in the project budget yet to successfully implement project activities, these necessary commodities must be purchased by ProVIC.

Further, USAID also requested that PATH procure ARVs for PMTCT, palliative care drugs and HIV/AIDS diagnostic test kits for partners (i.e. grantees) and health facilities included in the project's health intervention zones, since meeting the project objectives would be impossible without these commodities. This was not in the original scope of work, and the project had not planned on procuring pharmaceuticals, since it was understood that ProVIC would leverage donations for these from partners, such as the Global Fund and Clinton Foundation. However, it was immediately apparent upon project start-up that the

procurement of ARV's, in addition to test kits and related commodities would be necessary to support project activities since the pharmaceuticals we had expected to leverage from donors, were in fact already programmed and were facing a supply shortage.

Therefore, in April ProVIC hired a local consultant to quantify needs for groups of key products considered to be highest priority in keeping with current standard treatment guidelines, indicators and targets for the project, and available facility information. To avoid establishing parallel procurement and supply chain activities, ProVIC met with select stakeholders who supply PMTCT drugs, HCT supplies, and other commodities to clinics to mirror current standard treatment guidelines, identify the most appropriate vendors and supply chain mechanisms, and foster potential partnerships. The results of this quantification activity provided the basis for determining procurement needs to carry out project activities, and meet set targets. ProVIC also identified potential suppliers, negotiated quotes, reviewed quality assurances of suppliers, assessed regulatory standards for all pharmaceuticals requested, and ensured adherence to USAID criteria (i.e., source origin of manufactured commodity, FDA approval, etc.).

With USAID approval, ProVIC has now begun to purchase pharmaceuticals to support implementation of project activities. Specifically, we have procured a six-month supply of test kits from Wagenia, a local supplier based in Kinshasa, and are purchasing ARVs and cotrimoxazole from the IDA Foundation, based in the Netherlands.

Problems encountered and proposed solutions

- The slow and bureaucratic process required to register a project in the DRC delayed some hiring processes and hindered consortium members' ability to establish their presence in the country by opening bank accounts, shipping effects, and undertaking other essential activities. This process improved with the completion of preliminary registration steps, which enabled many of these activities to since advance. Not all consortium members, have since been able to fully complete their local government registrations; consequently, some staff are still working under consulting contracts rather than employment agreements. ProVIC will need to process multiple payrolls once all consortium members secure registration. We are currently researching payroll outsourcing to a local firm.
- Procurement challenges as outlined above have led to significant project delays. The quantification exercise (which yielded a comprehensive list of commodities needed), took many weeks to complete, as did discussions with suppliers and the PEPFAR/SCMS project to identify the select few who could provide us with specific pharmaceuticals (while adhering to USAID regulations and Congolese legal requirements). USAID approval then required several weeks due to complexities in seeking waivers for pharmaceutical purchases. Having now identified commodities needed and suitable suppliers, mastered the rigorous approvals process, and established procurement/shipping mechanisms, we do not anticipate future delays due to these logistical issues. We do, however, anticipate the following further procurement challenges as we scale up our activities in Year 2 and beyond should ProVIC continue to need to procure pharmaceuticals to support project activities (as opposed to leveraging these resources from another donor):
    - We will need to revise the procurement budget, since ProVIC had not budgeted for pharmaceuticals, and since we have therefore been spending far more than originally anticipated for procurement.

- We will need to map out a commodities storage, management and distribution plan, since the practice exercised to date (i.e., of storing shipments in the office) is neither practical nor sustainable.

Gender

Gender was identified as a critical component of the ProVIC project, both in terms of ensuring equitable access to services and contributing to overall results. A number of activities were implemented during the year to ensure that gender considerations are incorporated into our programmatic work, and that activities address the specific links between gender and HIV risk and vulnerability. A gender specialist guided a series of preparatory discussions and an assessment of gender issues relevant to ProVIC's work in the DRC, including:

- Participation in a *Technical Consultation on Scaling up the Response to Gender-Based Violence in PEPFAR,* convened by Assistant US Global AIDS Coordinator Michele Moloney-Kitts on May 6 and 7, 2010. PATH staff contributed to small group discussions focusing on BCC initiatives, highlighting promising strategies for strengthening community-level response to GBV and changing the norms that underlie its perpetuation.

US Global AIDS Coordinator Michele Maloney-Kitts visits ProVIC grantee: Fondation Femme Plus. ***Photo: ProVIC staff.***

- Discussions with ProVIC's CoP and DCOP to prepare for Ms. Moloney-Kitts' visit to the DRC in May focused on identifying potential entry points within ProVICs scope of work for integrating GBV. The idea of using the Champion Community model as a vehicle for addressing GBV was raised, and two specific areas were highlighted: first, the need to bridge the gap between existing services and community based support networks; and second, the need to fully engage communities in challenging norms around violence.
- Discussions with members of the gender technical working group spearheading the recently launched GBV scale up initiative in the DRC to discuss potential synergies with ProVIC work and in particular, the Champion Community model.
- Additional discussions with the CoP and DCOP to plan for an STTA gender assignment aimed at strengthening the ProVIC technical team's ability to integrate gender concerns into its programmatic work.
- An initial review of data, articles and studies on gender, GBV, and HIV in the DRC to contextualize and guide ProVIC's work in this area. The assessment highlighted a number of critical issues:
    1. Sexual violence continues to be used as a weapon of war, and stigmatization and fear of abandonment are issues of concern for many survivors. Civil society and human rights groups note that the stigma associated with rape can be as traumatic as the attack itself, and that certain populations are particularly vulnerable to social isolation.
    2. The prevalence of intimate partner or domestic violence was also highlighted. According to one study, the majority of sexual violence survivors presenting to a regional hospital had been attacked in their own homes. Such violence has been linked to a substantial proportion of new HIV infections in sub-Saharan Africa, but

the nexus with HIV risk and overall health outcomes remains unclear for many service providers and policymakers.

3. Comprehensive action plans and laws for addressing HIV and GBV exist but implementation remains a serious issue, usually linked to resource and capacity gaps.
4. Capacity among service providers to address gender-related issues that affect access to and use of services, and to responding meaningfully to GBV, remains weak. Gaps in response include the lack of standardized protocols and guidelines, inconsistent implementation of existing protocols, and inadequate attention paid to survivor's long term holistic needs.

GBV and SGBV have been described as normative in the DRC, and emerging data from the assessment, in tandem with other preparatory discussions appear to confirm this. Efforts to challenge deeply held norms and beliefs need to be anchored at the community level if they are to galvanize true, sustainable change.

The preparatory work described laid the foundation for a two-week (July 3 to 16, 2010) STTA mission conducted by the gender specialist, with the following objectives:

- Training ProVIC staff and selected partners in gender analysis and integration of gender - related issues into programmatic work.
- Strengthening ProVIC capacity to achieve expected outcomes through incorporation of activities aimed at addressing gender equity and harmful norms that impact prevention, care, support and treatment.
- Identifying opportunities for potential introduction of GBV work and engaging the PEPFAR team in discussions around specific approaches and activities for addressing SGBV.

Meetings were held with the Minister for Gender and other government entities, United Nations organizations, member of the DRC mission and PEPFAR team, and community based NGO partners. The gender specialist also visited the Centre D'encadrement pour Femmes Vulnérables, and Kimbaseke Champion Community sites. These discussions were pivotal to building collaborative relationships and shedding light on some of the assessment findings related to gender in the DRC.

A participatory workshop on gender analysis and integration for HIV/AIDS interventions was offered to staff on Friday, July 9, 2010, focusing on:

- Strengthening understanding of the importance and relevance of gender to ProVIC's work.
- Identifying gender related challenges and barriers to prevention, care and support.
- Highlighting promising strategies for addressing gender related challenges.
- Presenting evidence around the impact of integrating gender on overall health outcomes.
- Familiarizing participants with contextually relevant, easy-to-adapt tools and frameworks, including indicators for monitoring, evaluating progress and impact.

- These concepts and tools formed the basis for incorporating activities that address gender equity and harmful norms that impact prevention, care, support and treatment into the Y2 workplan, especially using ProVIC's Champion Communities as a framework for addressing gender.

The gender specialist was asked to guide discussions with the PEPFAR team around specific approaches for addressing SGBV and opportunities for building on and scaling up existing work. The discussions were an opportunity to reflect broadly on some findings from the assignment, highlighting in particular a) the lack of commitment at ministerial level b) the gap between the legal/policy framework and implementation at community level c) the need to link service provider with community based networks and support groups d) the need to train service providers on responding meaningfully to potential or disclosed violence, and e) the need to focus on interventions beyond provision of PEP that would address stigmatization faced by women living with HIV and violence. An indicator to measure the number of providers who could refer clients to community based groups such as Heal Africa or SWAA was suggested.

Environmental compliance

A biomedical waste incinerator in Kikanda before restoration. Photo: ProVIC staff.

In Year 1, ProVIC developed and implemented a comprehensive plan and guidelines for handling hazardous biomedical waste. This included assessing sites, identifying issues, and developing plans to resolve them (such as the purchase of new equipment). Training activities were also conducted to reinforce the capacity of HCT, PMTCT, and care and support service providers in managing biomedical waste.

During regular supervision visits, the ProVIC team noticed that several sites had malfunctioning incinerators that were supposed to ensure effective disposal of biomedical waste. ProVIC immediately responded to the dangers of these circumstances by rehabilitating the four identified incinerators in government health institutions, as follows: one incinerator was rehabilitated at the PNLS premises in Katanga and three others in the general hospitals of Kinkenda, Kiamvu, and Mvuzi in Bas Congo. In addition, supplies and other much-needed materials were provided to different ProVIC sites to ensure compliance with national environmental norms and USAID regulations.

In April 2010, the project was visited by two USAID auditors, Daniel Cabet and Cheikh Tidiane Talla, from the Office of the Inspector General. The aim of the visit was to assess ProVIC's compliance with US Government regulations on environmental management and protection of biomedical waste generated by project activities. Two site visits were conducted in Kinshasa and Matadi. The auditors' visit served as a learning opportunity for ProVIC to reinforce its strategies and mechanisms for ensuring compliance among grantees and health entities receiving USAID funding.

A biomedical waste incinerator in Kikanda following restoration. Photo: ProVIC staff.

One of the main lessons learned during Year 1 was that effective management of biomedical waste was not a priority for most of NGOs implementers, health facilities, and service

providers. The communities, as well as the private sector, were unaware of the risks associated with biomedical waste. Despite the existence of national norms that clearly provide guidance on how to collect, handle, store, transport, and eliminate hazardous biomedical waste, practices in the field are often inconsistent and far from acceptable.

In Year 2, ProVIC will continue to educate and train site staff, as well as provide them with the necessary equipment and facilities to ensure safe waste disposal.

SECTION 3. THE FUTURE

In his recent speech at the United Nations General Assembly on September 22, 2010, the President of the United States of America, Barack Obama, clearly laid out the blueprint for a development policy on international aid that will drive the US Government's efforts and determine the flow of US taxpayer money. His message was simple: the United States wants to help countries help themselves, not offer aid that provides short-term relief without reforming societies. Such aid that only offers short-term relief, the President said, "is not development, that's dependence.… It is a cycle we need to break. Instead of just managing poverty, we have to offer nations and people a path out of poverty."[3] Development should no longer be measured by how much money or medicine is delivered, but by the extent to which the United States helps communities sustainable empower themselves. "The purpose of development—and what is needed most right now—is creating the conditions where assistance is no longer needed. So we will seek partners who want to build their own capacity to provide for their people," the President concluded in his message on change for sustainable development.

ProVIC's mission is to bring about this much-needed and awaited, change. As stated in the introduction to this report, the main objective of the PEPFAR-funded USAID ProVIC project is to reduce the incidence and prevalence of HIV and mitigate its impact on people living with HIV/AIDS and their families. Underlying this stated purpose is a deeper vision and engagement process that constitutes the core strategy and driving force of ProVIC: the creation of "champion communities" that can become masters of their own future through the progressive, deliberate, and participatory practice of communities engaging in the collective definition and resolution of their own problems.

ProVIC and its many diverse partners at the local, regional, national, and international levels are working to create healthier, self-reliant, and vibrant communities within the project's intervention areas. We are achieving this by replicating an innovative yet proven model of community engagement in the fight against HIV/AIDS. This successful model will be scaled up from the current four Champion Communities to 40 in Year 2.

We will select local NGO partners with deep roots in, and solid knowledge of their communities, to implement our strategies within the context of the Champion Community approach. We will also support the opening of new HCT centers in our program sites and continue providing services at existing centers.

Ensuring the regular and timely supply of test kits, pharmaceuticals, and laboratory products for HCT, PMTCT, and care and support will be a priority for Year 2 as a means to support the delivery of quality services and meet program targets.

[3] Obama, Barack (September 2010). From www.realclearpolitics.com/.../2010/.../obama_address_to_the_united_nations_general_assembly_107285.html.

With other USAID program partners, such as TB 2015, we will intensify linkages and management of HIV-TB co-infection by ensuring that PLWHA are tested for TB. Within the scope of our care and support component, we plan to strengthen the capacity of PLWHA on positive living, positive prevention, and palliative care skills. In this same vein, we will address the needs of OVC by introducing the child to child approach to our NGO grantees, who will work with OVC champion communities, teachers, tutors, and others providing services to, and thereby empowering, OVC. While exploring and establishing more sustainable strategies, we will continue to provide educational, vocational, psychosocial, clinical, and economic support to OVC based on identified needs. We expect Year 2 to serve as a transitional period, after which we plan to begin phasing out the more traditional approach of offering 'handouts' and increasingly shift to introducing more sustainable activities.

We will continue to build and strengthen the capacity and systems of provincial government structures of MINAS, PNLS, PNMLS and the Ministry of Gender and Family, as well as our implementing partners. ProVIC will offer integrated trainings to service providers to improve the quality of services and address issues of stigma and discrimination toward PLWHA, OVC, and victims of gender-based violence.

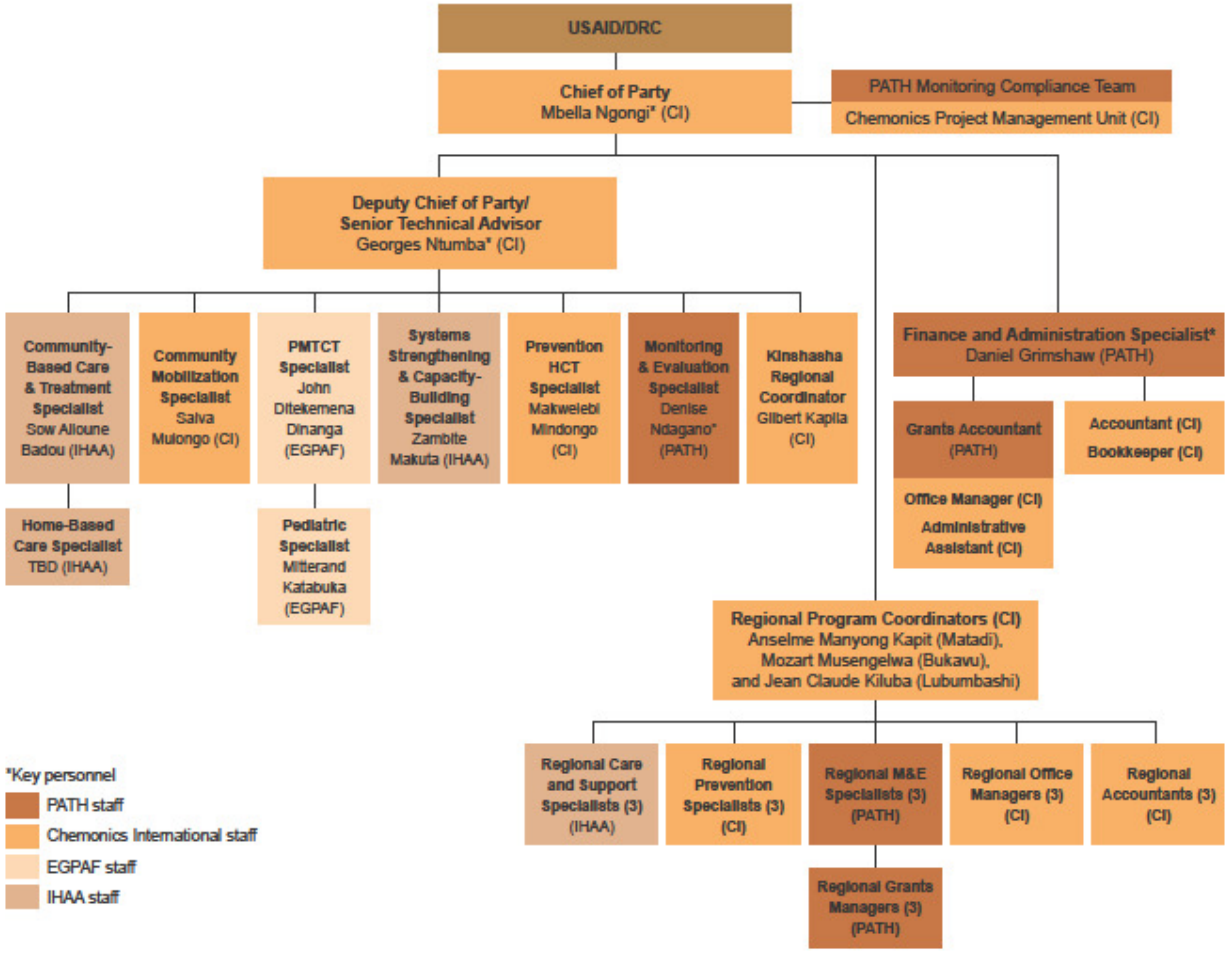
ProVIC's goals for the year ahead are ambitious yet achievable with the support of our partners within the international, national, and local NGO and donor community, the Government of DRC, the private sector, and of course, USAID/PEPFAR. Together, we can meaningfully impact the lives of the members of the communities that we seek to serve.

ANNEX A. FINANCIAL REPORT

Contract No: GHH-I-00-07-00061-00, Order No. 3
Report Date: October 30, 2010
Period Covered by this Statement: July 1, 2010-September 30, 2010

Budget Line Items	Total Budget	Current Obigation	Expenditures Current Period 7/1/10-9/30/10	Expenditures Project to Date 9/30/09-9/30/10	Current Obligation Remaining	Total Budget Remaining
Salary and Wages	2,724,498	621,710	117,499	339,593	282,117	2,384,905
Fringe Benefits	817,349	186,513	33,669	100,185	86,328	717,164
Travel and Transportation	723,607	213,435	56,767	138,228	75,207	585,379
Supplies	13,622	3,109	0	0	3,109	13,622
Contractual	25,672,205	6,121,009	890,313	3,734,231	2,386,778	21,937,974
Other Direct Costs	10,504,103	2,231,072	430,203	629,166	1,601,906	9,874,937
Indirect Costs	2,922,696	701,136	166,475	358,706	342,430	2,563,990
Subtotal Project Costs	43,378,080	10,077,984	1,694,925	5,300,108	4,777,876	38,077,972
Fixed Fee (at 4%)	1,495,123	403,119	67,797	197,754	205,365	1,297,369
Totals	44,873,203	10,481,103	1,762,723	5,497,862	4,983,241	39,375,341

ANNEX B. STAFFING ORGANIGRAM



ANNEX C. TRIP REPORTS

Franck Biayi

Prepared by: **Franck Biayi**
Dates: April-June 2010 (intermittently)
*Purpose***:** Commodities assessment

Introduction

Le projet intégré du VIH au Congo (ProVIC) est un programme de l'USAID/PEPFAR d'une durée de 5 ans visant les activités de lutte contre le VIH dans quatre « points chauds » situés dans quatre provinces de la RDC; Kinshasa, Bas Congo, Sud Kivu et Katanga. Le projet vise les objectifs ci-après:

1. Améliorer l'accès et la qualité des services de prévention, soins et traitement dans les 4 régions sélectionnées;

2. Augmenter l'implication des communautés dans le domaine de la sante en dehors des centres de santé en utilisant des approches communautaires qui assurent la durabilité;

3. Améliorer et augmenter la capacité du gouvernement et des partenaires (Organisation civiles de base) a planifier, gérer et livrer des services VIH/SIDA de haute qualité;

4. Appuyer le gouvernement à développer, propager et mettre en œuvre les politiques (e.g. de conseil et dépistage) basées sur des expériences vécues et vérifiées.

L'atteinte de ces objectifs nécessite l'approvisionnement en intrants de dépistage, les produits pour la prise en charge PTME, les infections Opportunistes, la planification familiale et les soins palliatifs.

Les Termes de références de la mission ont consisté à:

- Elaborer la liste des produits pour les besoins spécifiques du projet au cours des cinq années en matière de PTME et les soins palliatifs et établir les sources, l'achat, le stockage et la distribution.
- Déterminer les prochaines étapes et fournir des recommandations pour la planification des achats.
- Un outil de quantification pour les ARV et produits PTME (Est-il possible d'inclure des outils supplémentaires pour les kits de test HCT et produits de base MST?).
- Sur la base de l'évaluation locale, fournir des recommandations pour les méthodes de quantification appropriées pour les autres produits.
- Recommandations pour la dotation de projet pour gérer les marchés.
- Quantifier les besoins en ARV, produits HTC et des soins palliatifs.
- Fournir une formation de 3-4 heures pour l'équipe et les partenaires sur des méthodes de quantification des ARV et autres fournitures.
- Sur la base de réunions avec des intervenants locaux, un résumé des partenaires potentiels pour les achats locaux et de la distribution.
- Formuler toute recommandation nécessaire à la mise en œuvre efficace du projet dans les aspects d'approvisionnement.

Méthodologie

Nous avons réalisé la revue documentaire des plusieurs documents référencés dans ce rapport et conduits plusieurs entretiens avec les responsables des institutions étatiques, paraétatiques, des acteurs du secteur privé lucratif et non lucratif et le staff de ProVIC.

Résultats

1. La liste des produits pharmaceutiques

La liste des produits pharmaceutiques à utiliser dans le Projet Intégré de VIH au Congo (ProVIC), est catégorisée selon les domaines d'intervention du projet; il s'agit de produits pour le DEPISTAGE, les ARV destinés à la PTME, les produits pour INFECTIONS OPPORTUNISTES, les produits pour la PLANIFICATION FAMILIALE[4] et les produits pour les SOINS PALLIATIFS. Les documents de référence ont été consultés pour l'élaboration de ces différentes listes il s'agit de: Liste Nationale des Médicaments Essentiels version 2010, la Nomenclature PNAM rationalisée 2009, le Guide National de Traitement de l'infection à VIH par les antirétroviraux chez l'adolescent et l'adulte 2008, Normes et directives en conseil et dépistage volontaire du VIH 2004, le Guide Pratique de Prise en Charge des infections opportunistes et autres pathologies liées à l'infection à VIH en République Démocratique du Congo 2005. Des entretiens ont été conduit chez les responsables du PNLS, PNAM, PNMLS, Directions de la Pharmacie, Médicaments et Plantes Médicinales et la Direction de la lutte contre la maladie, le MSH, le staff technique de ProVIC.

Après la revue documentaire de tous les documents normatifs et les divers entretiens avec les différents responsables des services du ministère de la santé et des partenaires; nous avons élaborés la liste ci-après selon les domaines de prestation et les objectifs du projet et pour chaque item, les spécifications techniques sont données. Cependant il est à souligner le PNLS est dans le processus de révision des protocoles de prise en charge et il est donc possible que la fin de cette révision entraine la modification de cette liste pendant la mise en œuvre du projet.

Tableau 1: Liste des produits pour le dépistage

Produits	Présentation
Determine VIH 1& 2	KIT 100
Double check VIH 1& 2	Kit 20
Unigold HIV 1 & 2	Kit 20
Cryotubes 2ml	Bte 100 Pces
Tubes vacutainers, EDTA-K, 6ml	Bte 100 Pces
Tubes vacutainers, EDTA-K, 10 ml	Bte 100 Pces
Adaptateur aiguille vacutainers	Bte de 25 Pces
Aiguille vacutainer G21	Bte 100 Pces
Embout (0-200 µl)	1000 Pces
Pipette Pasteur plastic avec Bulbe de 3 ml	500 Pces
Gants non stériles	Bte 100 Pces
Micropipette 5à 50µ	Pce

[4] ProVIC ne sera pas chargé d'acheter les produits de planification familiale, mais poura etre responsabilisé de les distribuer dans les communautés championnes, dans le contexte de l'integration.

Produits	Présentation
Micropipette 10 à 100µ	Pce
Centrifugeuse manuelle	Pce
Chase buffer	Pce
Garrot	Pce
Sparadrap, oxyde de zinc en rouleau, 2 & 5cm	Pce
Marqueur indelibile	Bte 12 Pces
Alcool dénaturé 5L	bidon 5 Litres
Eau de Javel	Bidon 5 Litres
Coton hydrophile rouleaux 500g	1 rouleau

Tableau 2: Liste des ARV pour la PTME

Produits	Dosage	Conditionnement
Nevirapine co	200 mg	30
Zidovudine co	300mg	60
Zidovudine +Lamivudine	300+150	60
Efavirenz (EFV)	600mg	30
Zidovudine+Lamivudine+Névirapine	300+150+200	60
Tenofovir + Lamivudine+ Efavirenz	300+150+600	30
Lopinavir + Ritonavir	200/50	120
Abacavir	300 mg	60
Tenofovir	300 mg	60
Nevirapine (suspension)	10 mg/ml (50mg/5ml)	Flacon de 240ml

Tableau 3: Les produits contre les infections opportunistes

Produits	Présentation	Dosage
Cotrimoxazole	Comprimés B/1000	400+80 mg
Cotrimoxazole	Suspension orale Flacon de 100 ml	200+40 mg

Tableau 4: Les produits de la planification familiale

Produits	Forme	Dosage	Conditionnement
Depo-Provera (Déxomethyl-progesterone acetate/ DMPA)	Flacon inject	150 mg	B/25
Duofem (Levonorgestrel)	Pilule B/2	0,750 mg	B/2, unité
Microgynon (ethinyloestradiol)	Comprimé	0,03mg+o,15mg	
Microlut (Levonorgestrel)	B/28	30 mg	B/28, unité
Condom lubrifié masculin	Unité		B/144
Condom lubrifié féminin	Unité		Unité
Dispositif intra utérin en cuivre	Tcu380		B/50
collier du cycle	Unité		Unité
Implants Jadelle	Unité	2x75 mg	B/10

Tableau 5: Kit « CARE & SUPPORTS »

Produits	Présentation
Alcool dénaturé	Flacon de 100 ml 70%
Gants en latex stériles	7,5 paire
Bande cambric	Rouleau de 5x5
Ciseaux	
Sparadrap	Rouleau, 5cmx5 m, unité
Paracétamol	Comprimés de 500 mg
SRO	Sachet
Vaseline	Pot de 200g
Ouate hydrophile	250 g
Poudre antiseptique	250 g

2. Estimations prévisionnelles des besoins

Les méthodes d'estimation des besoins sont basées sur la collecte des informations pertinentes sur le programme et la logistique dans la zone géographique ciblée par le programme.

Ces informations peuvent être disponibles dans les documents tels que: les comptes rendus du système d'information en gestion logistique (SIGL) au niveau central, les prévisions précédentes des besoins, les anciens rapports sur les achats/passations de marché des médicaments et intrants, la politique de programme concernant les prestations de services dans les sites, les documents pertinents de planification de programme, les données démographiques.

Nos entrevues avec différents responsables et acteurs ont démontré l'absence de toutes ces données malgré l'existence des anciens programmes dans certains sites ciblés. Les raisons majeures de l'absence des données est l'inexistence d'un archivage bien tenu à tous les niveaux de la pyramide sanitaire.

Si on ne dispose pas des données fiables et d'une analyse attentive, les prévisions et les achats reviennent quasiment à deviner les besoins et c'est le cas pour les sites et provinces visés par le projet. C'est ainsi que nous avons estimé les besoins en médicaments et intrants en nous basant uniquement sur les **cibles du projet** et le staff ProVIC a proposé que nous ajoutions 20% à la cible l'année 2 pour obtenir l'année 3 et de même pour les années 4 et 5.

Tableau 6: Résumé des cibles du projet pour 5 ans

Domaines	Cibles	Année 1	Année 2	Année 3	Année 4	Année 5
Dépistage	Nombre des personnes (nombres des sites)	144700(40)*	200000(60)	240000(60)	288000(60)	345600(60)
	Femmes (PTME+Sites)	11500(24)*	23000(25)	27600(25)	33120(25)	39744(25)
PTME	Femmes (ARV+CTX)	230	460	552	662	795

Domaines	Cibles	Année 1	Année 2	Année 3	Année 4	Année 5
	Enfants (ARV + CTX)	230	460	522	662	795
	Femmes (PF)	230	460	522	662	795
Soins & supports	Nombre des Volontaires communautaires (Kit)	18500	33000	39600	47520	57024
	Nombre des PVVIH (IO)	8360	15400	18480	22176	26615
Planification familiale	Communauté championne	160000				
	Dépistage volontaire	144700	200000	240000	288000	345600
	PTME	230	460	552	662	795

( )* Nombre des sites

Besoins en tests de depistage volontaire

Le dépistage volontaire pour la première année concerne la cible contractuelle de 144700 à réaliser dans les Centres de Dépistage Volontaire (CDV mobiles et CDV intégrés) et 11500 dans les maternités pour la PTME soit un total contractuel de 156200 dépistages pour la première année et pour les autres années du projet; les cibles sont réparties dans le tableau 6.

Les bases pour effectuer le calcul sont les suivantes:

- Le Determine VIH 1&2: le nombre de tests doit correspondre à celui des personnes à tester soit 156200 (soit un test, un client)
- Le Double check VIH 1&2: considérant la prévalence nationale actuelle dans les sites sentinelles à 4,3% (Plan Stratégique PNLS 2008), nous avons relevé cette valeur à 10% des personnes qui pourraient être positives au test de Determine VIH1&2 en nous basant sur l'expérience du PNUD dans la quantification des besoins en intrants de dépistage.
- Unigold VIH 1&2: considérant également la prévalence nationale actuelle dans les sites sentinelles à 4,3%, nous avons relevé cette valeur également à 10% de la même manière que le double check VIH1&2.
- Les matériels tels que Cryotubes, tubes vacutainers, les adaptateurs, embouts, Gants non stériles, micropipettes, centrifugeuse, garrot……les données de calcul ont été prises sur base de l'expérience du Laboratoire National du Programme National de lutte contre le VIH/SIDA, il nous semble qu'il n'existe pas des hypothèses de calcul pour le petit matériel. Les besoins sont exprimés de manière aléatoire, les informations fournies par les techniciens du laboratoire du PNLS nous ont permis de proposer des bases de calcul en tenant compte du nombre des sites de dépistage (40 sites CDV et 24 sites PTME pour l'An 1 et 60 sites CDV et 25 sites PTME pour les années 2, 3, 4 et 5).
- Les stocks de sécurité sont calculés en raison de 20% pour le Determine VIH 1&2 et 5% pour le Double check VIH 1&2, Unigold 1&2 et les autres petits matériels selon les informations fournies selon l'expérience du Laboratoire National du programme National de Lutte contre le Sida et aussi de la prévalence nationale de VIH/SIDA qui est de 1,3% selon l'enquête EDS-RDC 2007.

Le tableau ci-après reprend les hypothèses proposées pour chaque item pour les stocks de sécurité pour la première année et qui sont utilisées pour les années suivantes.

Tableau 7: Les hypothèses de calcul pour chaque item pour cibles CDV et PTME et le % en stock de sécurité

Produits	Présentation	Cibles	Qtite tests	Hypothèse Stock de Sécurité en %
Determine VIH 1& 2	KIT 100	156200	Correspond au nombre des personnes à tester selon le principe « un test, un client »	20
Double check VIH 1 & 2	Kit 20	15620	Calculer sur 10% de Determine	5
Unigold HIV 1 & 2	Kit 20	15620	Calculer sur 10% de Determine	5
Cryotubes 2ml	Bte 100 Pces	156200	Calculer sur 10% d'échantillons positifs attendus (15620) plus 10% d'échantillons négatifs attendus(14058)	5
Tubes vacutainers, EDTA-K, 6ml	Bte 100 Pces	156200	Calculer sur 30% de la cible	20
Tubes vacutainers, EDTA-K, 10 ml	Bte 100 Pces	156200	Calculer sur 70% de la cible	20
Adaptateur aiguille vacutainers	Bte de 25 Pces	156200	7810	20
Aiguille vacutainer G21	Bte 100 Pces	156200	Correspond au nombre des prélèvements à effectuer (156200)	20
Embout (0-200 µl)	1000 Pces	156200	La somme totale des tests Determine, Double check et Unigold à réaliser	10
Pipette Pasteur plastic avec Bulbe de 3 ml	500 Pces	156200	Correspond au nombre des prélèvements à effectuer	10
Gants non stériles	Bte 100 Pces	156200	Correspond au nombre des prélèvements à réaliser	20
Micropipette 5 à 50µl	Pce		Estimer à 3 micropipettes par CDV (mobile et intégré)	0
Micropipette 10 à 100 µl	Pce		Estimer à 3 micropipettes par CDV (mobile et intégré)	0
Centrifugeuse manuelle	Pce		Estimer à 3 par laboratoire	0
Chase buffer	Pce	156200	Le laboratoire national du PNLS ne recommande pas systématiquement l'utilisation de ce tampon à cause de la subjectivité dans la lecture des résultats, raison pour laquelle nous avons estimé les besoins à 1 Chase buffer pour 100 tests de Détermine soit 1562	20

Produits	Présentation	Cibles	Qtite tests	Hypothèse Stock de Sécurité en %
Garrot	Pce		Estimer à 3 par laboratoire	0
Sparadrap, rouleau 5x5 cm	Pce	156200	Estimer sur un rouleau pour 5 patients	20
Marqueur indélébile	Bte 12 Pces		Calculer sur 10 marqueurs par mois par structure	20
Alcool dénaturé 5L	bidon 5 Litres		Estimer sur 1 bidon de 5 l par mois par structure	0
Eau de Javel	Bidon 5 Litres		Estimer sur 2 bidons de 5L par mois par structure	0
Coton hydrophile rouleaux 500g	Pce		Estimer à 3 rouleaux par mois par structure	0

Ces hypothèses de calcul nous permettent ainsi de calculer les besoins de chaque item (CDV et dépistage pour PTME) en partant du principe d'un nouveau programme. Les résultats se résument dans le tableau 9 ci-après (Il faut souligner que les besoins en petits matériels et autres intrants pour les sites PTME sont dans les tableaux N° 10 et 12) et la réduction de la quantité de chaque item peut être calculé par mois sauf pour le petit matériel qui doit couvrir plus de 12 mois (Les détails de calcul sont dans l'annexe électronique: Estimation HTC Y1).

Il faut souligner que les cibles annuelles étant les bases de calcul; le « Performance Monitoring and Evaluation Plan » ou « PMEP » ne fixe les cibles que pour les années 1 et 2, le Staff ProVIC a proposé une augmentation annuelle de 20% partant des cibles de l'année 2 en vue d'avoir les cibles pour les années 3,4 et 5. Il est cependant important de souligner que les besoins quantifiés des années 2, 3, 4 et 5 dépendront essentiels du Système d'Information de Gestion Logistique (SIGL) mis en place qui permettra de quantifier les besoins sur bases de données de consommation liées à la capacité de chaque structure de mettre en œuvre les activités de dépistage. Les quantités des produits des années 2, 3, 4 et 5 sont donc calculées à titre indicatif; ce principe est aussi d'application pour tous les autres produits du projet.

Tableau 8: Besoins indicatifs en tests de dépistage (KIT) pour 5 ans

Produits	Présentation	Nombre Kit An 1	An 2	An 3	An 4	An 5
Determine VIH 1&2	KIT 100	1875	2676	3212	3855	4626
Double check VIH 1&2	Kit 20	821	1171	1406	1688	2026
Unigold HIV 1&2	Kit 20	821	1171	1406	1688	2026
Cryotudes 2ml	Bte 100 Pces	312	424	509	611	734
Tubes vacutainersEDTA-K,6 ml	Bte 100 Pces	563	803	964	1157	1389
Tubes vacutainers EDTA-10 ml	Bte 100 Pces	1313	1874	2249	2699	3239
Adaptateur aiguille vacutainers	Bte de 25 Pces	375	536	644	773	928

Produits	Présentation	Nombre Kit An 1	An 2	An 3	An 4	An 5
Aiguilles vacutainers G21	Bte 100 Pces	1875	2676	3212	3855	4626
Embout (0-200 µl)	1000 Pces	277	295	354	425	510
Pipette Pasteur plastic avec bulbe de 3ml	500 Pces	344	344	413	496	596
Gants non stériles	Bte 100 Pces	1875	2676	3212	3855	4626
Micropipette 5-10 µl	Pce	120	180	0	0	0
Micropipette 10-100 µl	Pce	120	180	0	0	0
Centrifugeuse manuelle	Pce	120	180	0	0	0
Chase Buffer	Pce	1875	2676	3212	3855	4626
Garrot	Pce	120	180	0	0	0
Sparadrap 5x5	Pce	37488	53520	64224	77069	92483
Marqueur indélébile	Bte 12 Pces	480	720	720	720	720
Alcool dénaturé	bidon 5 Litres	480	720	720	720	720
Eau de Javel	Bidon 5 Litres	960	1440	1440	1440	1440
Coton hydrophile 500 g	Pce	1920	2880	2880	2880	2880

Besoins en produits PTME

Les produits PTME sont estimés pour les 5 ans du projet avec comme base les cibles détaillés dans le tableau 7, de la même manière; les besoins estimés pour les années 2, 3, 4 et 5 sont à titre indicatif et que la quantification pour ces années dépendra des informations générées par le Système D'Information de Gestion Logistique mise en place au cours de l'année 1 d'activités.

Tableau 9: Besoins indicatifs en ARV pour PTME (ARV adultes et pédiatriques) pour les 5 ans

Produits	Présentation	Quantité An 1	Quantité An 2	Quantité An 3	Quantité An 4	Quantité An 5
Zidovudine co 300 mg	60	1173	2345	2814	3377	4053
Nevirapine co 200 mg	30	47	93	112	135	162
Zidovudine co +Lamivudine 300 +150 mg	60	369	737	885	1062	1275
Efavirenz co 600 mg	30	774	1547	1857	2229	2675
Zidovudine co+Lamuvidine +Nevirapine co	60	932	1864	2237	2685	3222

300+150+200 mg						
Lopinavir/Ritonavir 200+5 mg	120	41	81	98	118	142
Abacavir co 300 mg	60	77	153	184	221	266
Tenofovir co 300 mg	60	153	306	368	442	531
Tenofovir+Lamivudine+ Efavirenz 300+150+ 600 mg	30	644	1288	1546	1856	2228
Nevirapine suspension	Flacon	381	762	915	1098	1318

Besoins en produits care & support

Les cibles prévues pour ce domaine sont respectivement 18500 qui doivent bénéficier d'un KIT des soins à travers les volontaires communautaires et 8630 qui doivent bénéficier des médicaments contre les IO soit le Cotrimoxazole qui est déjà pris en compte dans les besoins des infections opportunistes.

Nous avons constitué les différents Kit avec l'aide de l'équipe CARE & SUPPORTS et utilisant en partant du principe que chaque PVVIH devra recevoir au moins un KIT par an dont la constitution est proposée dans le tableau ci-dessous.

Tableau 10: Composition du kit care & supports

Produits	Présentation	Quantité
Alcool dénaturé	Flacon de 100 ml 70%	1
Gants en latex stériles	7,5, paire	2
Bande cambric	rouleau de 5x5	2
Ciseaux		1
Sparadrap	rouleau, 5cmx5 m, Unité	1
Paracétamol	comprimés de 500 mg	20
SRO	Sachet	5
Vaseline	Pot de 200g	1
Ouate hydrophile	250 g	1
Poudre antiseptique	250 g	1

Tableau 11: Besoins indicatifs des produits care & supports pour 5 ans

Produits	Présentation	Quantité An 1	Quantité An 2	Quantité An 3	Quantité An 4	Quantité An 5
Alcool dénaturé	Flacon de 100 ml 70%	18500	33000	39600	47520	57024
Gants en latex stériles	7,5, paire	37000	66000	79200	95040	114048
Bande cambric	rouleau de 5x5	37000	66000	79200	95040	114048
Ciseaux		18500	18500	6600	7920	9504
Sparadrap	rouleau, 5cmx5 m, Unité	18500	33000	39600	47520	57024
Paracétamol	comprimés de 500 mg B/1000	370	660	792	950,4	1141,2
SRO	Sachet	92500	165000	165000	237600	285120

Vaseline	Pot de 200g	18500	33000	33000	47520	57024
Ouate hydrophile	250 g	18500	33000	33000	47520	57024
Poudre antiseptique	250 g	18500	33000	33000	47520	57024
MII		18500	18500	6600	7920	9504

Besoins en produits pour infections opportunistes

En nous référant au tableau 7; les cibles fixées pour le traitement des infections opportunistes proviennent respectivement du domaine de la PTME avec les femmes enceintes, les enfants nés de ces femmes et de celui de CARE&SUPPORTS.
Le médicament retenu pour les infections opportunistes est le Cotrimoxazole comprimés pour les adultes et la forme suspension pour enfants. Les besoins estimatifs du Cotrimoxazole vont être calculés ensemble (la PTME et CARE& SUPPORTS).

Les détails sur les calculs réalisés sont dans 2 feuilles Excel en annexe électronique (Budget CTX et Estimation CARE&SUPPORTS).

Tableau 12: Besoins estimatifs du Cotrimoxazole pour 5 ans

Produits	Présentation	Quantité An 1	An 2	An 3	An 4	An 5
Cotrimoxazole	Co 400+ 80 mg B/1000	15524	27788	33346	40014	48024
Cotrimoxazole	Suspension 200+40 mg Flacon 100 ml	1150	2300	2760	3312	3975

Besoins en produits de planification familiale

La planification familiale concerne les cibles détaillées dans le tableau 7, elles sont constituées des personnes attendues pour le dépistage volontaire, les femmes pour la PTME et les cibles de la communauté championne.

Nous avons estimé les besoins en produits de planification familiale en tenant compte de la proportion des femmes en âge de procréer (21%) et surtout de la prévalence des méthodes contraceptives (EDS-RDC 2007) et du nombre d'item utilisé par an (12 mois) en référence aux documents du PNSR (Module de formation en commodités SR).

Cependant, les femmes PVVIH bénéficiaires du programme PTME seront mises sous planification familiale uniquement par les méthodes à longue durée. Les prévisions couvrent la contraception de ces femmes durant les 5 années du projet. Le risque de surestimation des besoins est possible dans l'hypothèse ou une certaine proportion des femmes décident d'arrêter la contraception. D'ou l'importance de mettre en place le Système d'Information de

Gestion Logistique (SIGL) qui puisse anticiper sur les besoins pour éviter les surstocks qui conduiront à la preemption.

Tableau 13: Hypothèses de calcul pour les produits de planification familiale

Dénomination Commune Internationale	Forme	Dosage	Taux d'utilisation en %	Nombre des produits/an
Depo-Provera (Déxomethylprogesterone acetate DMPA)	Flacon injectable	150 mg	0,3	4
Duofem (Levonorgestrel)	Pilule	0,750 mg	0,2	2
Microgynon (ethinyloestradiol)	Pilule		0,8	15
Microlut (Levonorgestrel)	Pilule B/28	30 mg	0,8	15
Condom lubrifié masculin	Unité		4,8	120
Condom lubrifié féminin	Unité		1	150
Dispositif intra utérin en cuivre	Unité		5	1
Collier du cycle	Unité		1	1
Implants Jadelle	Unité		0,2	1

Tableau 14: Besoins en produits de planification familiale pour les FAP attendues dans les CDV

Produits	Présentation	An 1	An 2	An 3	An 4	An 5
Depo-Provera (Déxomethylprogesterone acetate DMPA)	Flacon inject 150 mg	437	599	718	862	1034
Duofem (Levonorgestrel)	Pilule B/2 0,750	147	200	240	288	345
Microgynon (ethinyloestradiol)	Comprimé 0,03+0,15 mg	4356	5982	7179	8614	10337
Microlut (Levonorgestrel)	B/28 30 mg	4356	5982	7179	8614	10337
Condom lubrifié masculin	Unité	208080	287125	344550	413462	496151
Condom lubrifié féminin	Unité	54360	74772	89727	107673	129206
Dispositif intra uterin en cuivre	Tcu380	1810	2493	2910	3590	4307
Collier du cycle	Unité	363	499	599	718	862
Implants Jadelle	Unité	74	100	120	144	173

Tableau 15: Besoins en Condom masculin lubrifié pour les personnes autres que les FAP attendues dans les CDV

Produits	Présentation	An 1	An 2	An 3	An 4	An 5
Condom lubrifié masculin	Unité B/144	95261	131667	158000	189600	227520

Tableau 16: Besoins en produits de planification familiale pour les femmes PVVIH attendues dans la PTME

Produits	Présentation	An 1	An 2	An 3	An 4	An 5
Depo Provera (Déxomethyl progesterone acetate DMPA)	Flacon inject 150 mg	276	2208	2650	3178	3816
Condom lubrifié masculin	B/144	33120	66240	79488	95328	114480
Condom lubrifié féminin	Unité	540	900	1080	1260	1440

Tableau 17: Besoins en produits de planification familiale pour les FAP du domaine de communauté championne

Produits	Présentation	Quantité An 1
Depo Provera (Déxomethyl progestérone acétate DMPA)	Flacon inject 150 mg	485
Duofem (Levonorgestrel)	Pilule B/2 0,750	164
Microgynon (ethinyloestradiol)	Comprimé, 0,03+0,15 mg	4842
Microlut (Levonorgestrel)	B/28, 30 mg	4842
Condom lubrifié masculin	B/144	232272
Condom lubrifié féminin	Unité	60480
Dispositif intra uterin en cuivre	Tcu380	2016
Collier du cycle	Unité	404
Implants Jadelle	Unité	82

Tableau 18: Besoins en condom masculin lubrifié pour les personnes autres que les FAP du domaine de communauté championne

Produits	Présentation	Quantité AN 1
Condom masculin lubrifié	B/144	105334

3. La Planification des achats

La planification des achats est une activité importante qui doit être réalisée dans les activités d'approvisionnement. Le plan d'achat est basé sur la liste des produits itemisé. Le cout totale des achats d'intrants va dépendre de la cotation des fournisseurs devant participer au marché d'une part et d'autre part les cibles prévu durant la mise en œuvre du projet; ce qui va dépendre notamment sure le budget global du projet consacré aux activités d'approvisionnement.

En attendant il pourra être possible de préparer un plan d'achat pour l'année 2 étant donné que les besoins sont connus. Ce plan contiendra les activités à mener dans un calendrier précis. Ces activités sont:

- Déterminer les besoins nécessaires en produits et réactifs de dépistage.

- Concilier les besoins exprimés et le budget disponible.
- Choisir la méthode d'achat (Appel d'offre international, appel d'offre restreint, consultation restreinte…rédiger le cahier de charge).
- Identifier et sélectionner les fournisseurs.
- Spécifier les contrats.
- Passer les commandes.
- Recevoir et vérifier l'état des produits.
- Procéder aux payements.
- Distribuer les produits.
- Collecter les données de consummation.
- Réviser la sélection des produits.
- Déterminer les quantités necessaries.

Le plan d'achat qui intègre un appel d'offre international exige un délai de plus ou moins 6-8 mois avant la réception des produits. Cependant une sélection préalable des fournisseurs ou un achat local peuvent raccourcir les délais de ce plan pour la réception des produits. Il sera impérieux d'élaborer dans les plus brefs délais un plan d'achat couvrant les 5 ans.

4. Les outils de quantification des ARV et produits de dépistage

Il existe quelques outils de quantification des ARV et en RDC parmi lesquels les plus utilisés sont « **ARV QUANT 2009 »** fourni par **Fondation Clinton** et « **GIS-MED »** développé par le **PNUD/FM et PNAM**. Ces outils de quantification conditionnées par la maîtrise des informations du système logistique (stocks disponibles, consommations, ruptures de stock, quantités en commande, pertes….) sans ces informations ou avec des informations erronées; l'utilisation des outils devient aléatoire. Par ailleurs le GIS-MED permet de quantifier les besoins des ARV y compris les intrants de dépistage……, l'utilisation demande néanmoins un nouveau paramétrage pour l'adapter au système sanitaire tandis que l'ARV QUANT 2009 de Fondation Clinton ne permet pas la quantification des intrants de dépistage. L'utilisation de ces deux outils nécessite une formation qui peut être donnée par la Fondation Clinton et le PNUD/FM.

MSH a développé également un outil **« QUANTIMED** » qui pourrait être utilisable en RDC vers la fin de l'année 2010. Le **PNAM** vient d'acquérir de l'UNFPA, le logiciel de gestion des médicaments **« CHANNEL** » qui peut réaliser la quantification et gestion de stock des médicaments et intrants de dépistage. Ce logiciel sera mis en place dans une expérience pilote à Kinshasa et Matadi au cours de cette année. Une session de formation est en cours de planification au PNAM pour l'utilisation de l'outil.

5. Les sources d'approvisionnement

Les sources d'approvisionnement des médicaments ARV sont essentiellement internationales et les exigences liées à la qualité par leur qualification par l'OMS ou par les autorités des pays à forte réglementation pharmaceutique (USFDA) font que les sources d'approvisionnement sont essentiellement internationales particulièrement en Inde.
Les principaux fabricants des ARV sont: CIPLA, HETERO, RAMBAXY, MATRIX, AUROBINDO, MACLEODS, STRIDES et d'autres qui produisent les génériques: ASPEN PHARMACARE, GLAXO……De ces fabricants; CIPLA et HETERO ont une représentation en RDC. Les fournisseurs qui participent le plus souvent aux marchés dans le pays sont: IDA Fondation, Mission Pharma, Imress.

Pour le processus d'achat, nous recommandons l'utilisation d'une entrée unique par Kinshasa avec **l'INCOTERM CCI-2000 –CIF Kinshasa** pour des raisons pratiques (faible quantité des produits) de réduction de coûts d'approche, d'obtention des exonérations et de contrôle des délais de livraison. L'utilisation des plusieurs portes d'entrée fait apparaître les risques d'augmentation des coûts d'approche et surtout de non contrôle des procédures de dédouanement et contrôle de qualité qui peuvent se répercuter sur les délais de livraison.

6. Achats locaux

Au niveau local, quelques fournisseurs tels que: Wagenia SPRL, Essor équipements assurent la distribution particulièrement des produits de dépistage. Cependant il faudra s'assurer au préalable de la qualification des produits distribués par eux et les agréments avec les fabricants. Wagenia Pharma disposerait des qualifications des produits (tests de dépistage) et des agréments des fabricants internationaux. Il pourra jouer un rôle important pour les achats de soudure et d'urgence et aussi participer aux divers marchés lancés par ProVIC. Concernant les produits tels que pour les soins palliatifs et le Cotrimoxazole; ils peuvent être achetés comme indiqués ci-haut dans les CDR de Kinshasa (CAMESKIN), à Matadi (CAAMEBO), tandis que pour le Sud Kivu il est possible de s'approvisionner à ASRAMES à Goma et les acheminer à Bukavu. Ces CDR obtiennent les produits du Bureau de Coordination des Achats FEDECAME (BCAF) qui est en convention avec l'Etat congolais pour les achats publics groupés. Ses procédures d'achat et son système d'assurance qualité ont été validés et acceptés par l'Union Européenne et la Banque Mondiale. Il est également possible de s'approvisionner localement chez des fournisseurs locaux qui ont été audités favorablement par le BCAF et la Direction de la Pharmacie, Médicaments et Plantes Médicinales, il s'agit de: ZENUFA, NEW CESAMEX, PHATKIN et PHARMAKINA qui sont pré qualifiés par le FEDECAME pour une liste limitée des médicaments.

Etant donné l'existence à Bukavu des dépôts pharmaceutiques à but non lucratif (BDOM, APAMESK…) une évaluation préalable des procédures « d'assurance qualité » de ces dépôts pourra permettre d'effectuer des achats localement. A Lubumbashi au Katanga l'absence d'une CDR fonctionnelle pose le problème d'approvisionnement en médicaments de qualité. Considérant l'éloignement des 2 autres CDR du Katanga (Kalemie et Kamina) de Lubumbashi; il serait plus raisonnable d'approvisionner Lubumbashi à partir de Kinshasa car le trafic aérien bien que onéreux est très important entre les 2 villes. La Centrale de Lubumbashi « CAMELU » qui dispose des entrepôts lui octroyée par la GECAMINES n'a d'autres activités que l'entreposage des produits des partenaires et la livraison.

7. Stockage et distribution

Les produits achetés en international peuvent être tous entreposés dans la Centrale de Kinshasa (CAMESKIN) qui fera un premier entreposage de transit (à durée très limitée) avec comme principe de ne pas garder du stock important, les produits estimés à environ 6 mois de stock partiraient pour un second entreposage principal à CAAMEKI à Kisantu (Bas Congo), CAAMEBO à Matadi (Bas Congo), à CAMELU à Lubumbashi (Katanga) et à BDOM ou APAMESK à Bukavu (Sud Kivu). Les quantités à envoyer de CAMESKIN aux autres CDR sont liées à la désagrégation préalable des cibles réparties d'abord par les quatre provinces et ensuite une seconde désagrégation pour la répartition des cibles par zones de santé et finalement par sites dans chaque zone de santé. Ce système de distribution exigera l'utilisation du mode « PUSH » de CAMESKIN vers les trois autres CDR car le stock à ce niveau est temporaire pour tous les produits destinés aux autres provinces. Ce système d'organisation permettra dans la mesure du possible de faciliter la « réallocation » des

produits entre CDR. Le mode « PULL » des CDR aux structures des zones de santé (sites CD, PTME…) sera appliqué avec un préalable d'un renforcement de capacité au niveau des prestataires pour la maîtrise des exigences de la quantification des besoins (remplissage des outils de gestion, détermination de la consommation mensuelle moyenne, réalisation de l'inventaire, fixation du facteur de réapprovisionnement et détermination de la quantité à commander, mesure du risque de sur-stock et sous-stock).

Tableau 19: Répartition des zones de santé par provinces et par CDR

Provinces	CDR	Zones de santé
KATANGA	CAMELU (Lubumbashi)	Kampemba, Kenya, Kipushi Lualaba, Manika, Panda, Rwashi Kikula
BAS CONGO	CAAMEBO (Matadi)	Boma, Matadi, Lukula, Nzanza Sekebanza
	CAAMEKI (Kinsantu)	Kimpese, Mbanza Ngungu
SUD KIVU	APAMESK (Bukavu)	Bagira, Kadutu, Ibanda Nyantende, Uvira
	BDOM (Bukavu)	Idem
KINSHASA	CAMESKIN	Mbiza Meteo, Nsele, Ngiri Ngiri, Kingasani, Kintambo, Mont Ngafula I, Kalamu, Matete, Lingwala, Masina I et Maluku.

De manière générale les conditions de stockage et conservation des médicaments sont adéquates dans ces structures et les informations sur les structures approvisionnées (zones de santé ou autres) peuvent être disponibles en temps réel.

8. Les coûts d'approche et logistique

Acheter du médicament est une chose et le rentrer en stock en est une autre. Entre le prix d'achat et le coût d'achat; il y a une différence que nous appelons les « coûts d'approche ». On parle de coûts d'approche lorsque l'acheteur doit, après avoir payé son fournisseur de médicaments, payer des services, des taxes ou des fournitures afin de rentrer ses médicaments en stock par exemple l'acheteur « ProVIC » qui doit rentrer le stock à CAMESKIN et donc faire face aux coûts d'approche tels que: les frais de douane, contrôle de qualité frais de transport, taxe administrative (si applicable), manutention, convoyage…..

Nous détaillons ici les différents coûts:

1. Importation (non applicable pour les achats locaux)
   - Achats formulaires DPM — **5 $US**/formulaire
   - Frais opérationnels
     - Laissez suivre — entre **25-150$US**
     - Photocopies pour des produits pesant — < 500kg : **15$US**; >500 kg :**30$US**
   - Douane
     - Redevance administrative: 5% de la valeur CIF (Il est important de vérifier si cette redevance est payée par USAID)
     - OCC (tally) — Minimun à payer **100 $US**
     - OCC analyse — **127 $US** par lot
     - Frais d'établissement IE — **25 $**US
     - Frais d'établissement/obtention E-U — **150 $**US
     - Redevance informatique — **30 $US**

- Imprimés **30 $US**
  - C. Frais entrepôts
    -Manutention: < 100kg **15 $US**
    < 500kg **35 $US**
    < 1000kg **50 $US**
    > 1000 kg **0,045$US/kg**
    > 8000kg **0,035$US/kg**
- Frais EPC prise en charge **4$US**
  - Frais d'Agence: selon l'agence contractée

NB: Il est important de vérifier sur base de l'expérience vécue pour les importations des produits précédemment effectuées par ProVIC de voir parmi les frais mentionnés; lesquels sont assujettis au projet malgré les exonérations obtenues.

2. Frais de Gestion CDR

Le projet peut s'appuyer sur les CDR pour assurer le stockage des intrants et médicaments destinés aux structures des zones de santé. Les conditions de stockage à travers les CDR sont liées au paiement des frais de gestion qui sont selon les directives PNAM; fixés par **m² occupé** à **368 $US** pour les consommables médicaux, **424 $US** pour les médicaments sans conditions particulières de conservation et **479 $US** pour les produits nécessitant la chaîne de froid. Ces coûts sont payés pour couvrir une période de 6 mois. Ces frais comprennent le stockage des produits et la production des rapports.

3. Transport

*2.1 Coût de transport **Aéroport vers CAMESKIN** (non applicable pour les produits achetés localement)*

Le coût de transport de l'Aéroport à la CAMESKIN pour des produits importés est évalué selon le poids des fournitures:

Poids	Coût
100 kg	30$US
<500 kg	50$US
<1000kg	80$US
>1000kg	100$US

NB. Lorsque le poids dépasse 1000kg, on paye 50$US pour chaque tonne supplémentaire.

*2.2 Transport aérien **CAMESKIN (ou autre fournisseur local) vers BUKAVU, Lubumbashi***

Le transport aérien en RDC est onéreux et le coût moyen est **1,5$US/**kg transporté, il sera donc important d'évaluer les coûts de transport aérien en fonction des quantités qui seront envoyés à Lubumbashi et à Bukavu. Ce coût prévisionnel peut être estimé à partir du poids des produits destinés à ces provinces.

*2.3 Transport **terrestre CAMESKIN (ou autre fournisseur local) vers CAMEKI, CAMEBO (Kisantu et Matadi)***

Le transport de Kinshasa(CAMESKIN) vers Kisantu et Matadi coûte en moyenne **1000$US** quelque soit la quantité des produits transportés. Nous proposons une envoie semestrielle des produits soit 2 envoies annuelles.

*2.4 Transport terrestre des **CDR vers les Sites d'utilisation***

Le coût de transport entre les CDR et les sites d'utilisation est estimé actuellement à **2%** du prix des produits à transporter. Le budget destiné à cette activité est lié à la valeur des produits qu'une CDR doit transporter vers les sites d'utilisation et les fréquences de transport (mensuel, trimestriel). Il est donc important de déterminer par rapport aux cibles attendues de chaque site, la quantité et la valeur des produits.

9. Budget estimative

Le budget indicatif est obtenu en additionnant les prix des différents produits du projet comme indiqué dans le tableau ci-dessous les détails sont dans les annexes électroniques « Estimation et Budget ».

Tableau 20: Le budget indicatif pour les produits du projet pendant 5 ans

Domaine	Montant
Dépistage volontaire	4917376,82
PTME	513633,99
Infections opportunistes	2329771,92
Care & supports	3223126,58
TOTAL	**10.983.909,3**

A ce budget indicatif, il faut ajouter les coûts des services (manutention, convoyage, contrôle de qualité, autorisations d'importation…..), les frais de gestion au niveau de CDR, les frais logistique pour assurer le transport des CDR vers les sites (CDV, formations sanitaires)
Le budget estimatif pour les coûts d'approche peut être réalisé en se basant sur les achats effectués récemment pour 6 mois, il s'agira de documenter les coûts par rapport à toutes les formalités requises et le transport jusque dans les locaux de ProVIC. A ces coûts il faut ajouter les frais de gestion pour stockage chez CAMESKIN pour une surface de stockage de 10m² (par hypothèse) soit 424 $US X 10= 4240 $US à payer et couvrant 6 mois. Etant donné que les produits transitant par CAMESKIN pour des destinations dans d'autres provinces n'auront qu'une brève durée de stockage, ce coût peut être discuté avec CAMESKIN pour le réduire à 1,2…mois. Tandis que les coûts de gestion dans les toutes les CDR qui stockent pour les structures doivent prendre en compte des durées plus longues (12 mois par exemple) car les structures d'utilisation seront astreintes au système « PULL » qui est dépendant de leur niveau d'activités et donc leur capacité de consommation. Les frais de gestion pour chacune des CDR seraient dans ce cas de 424 $US X 5 m² (dans l'hypothèse de 5 m² occupés) X 2 (semestres)= 4240 $US à payer pour 12 mois et le coût pour 5 ans pour 5 CDR serait: 4240 x 5 CDR x 5 ans= 106000 $US.

Le transport des produits peut être assuré par les CDR vers les structures d'utilisation (sites CDV, PTME….) avec un coût estimé à 2% (appliqué actuellement par les CDR ayant la logistique de transport) de la valeur des produits à transporter. La budgétisation prévisionnelle peut être donc estimée à 2% de **10.983.909,3 $US soit: 219678,18 $US.**

Le budget global prévisionnel pour les approvisionnements pour 5 ans serait constitué de:	
Achat produits:	10983909,3$US
Frais de stockage (hypothèse):	106000$US
Frais de transport CDR vers sites:	219678,18 $US

Frais de destruction des périmés et hors usage:	forfait à déterminer
Frais de formalités pour dédouanement:	à déterminer en fonction des quantités à acheter et la fréquence des achats internationaux

10. L'information

La mise en œuvre de ce projet nécessite impérativement la mise en place d'un Système d'Information de Gestion Logistique (SIGL) qui permettra de faire une gestion des stocks qui puisse réduire les risques de ruptures de stock ou les surstocks. Ainsi il sera indispensable d'établir un circuit « matière » dont le point d'entrée est la Centrale de Distribution Régionale de Kinshasa la CAMESKIN qui assurera la distribution primaire vers les trois autres provinces à travers les quatre centrales (CAAMEBO,CAAMEKI,CAMELU,BDOM ou APAMESK) qui couvrent les structures de zones de santé ciblées. Cependant dans le cadre de la rationalisation du stockage, les produits achetés localement peuvent quitter directement les sites d'achats (tels que WAGENIA) pour être envoyés vers les CDR dans les provinces. Cela exigera un suivi particulier qui devra élaborer le plan de distribution, organiser sa mise en œuvre et ainsi produire l'information relative à la distribution vers les provinces.
L'information à produire sera dans divers formats de rapport selon les données attendues:

CAMESKIN produira quatre rapports

- Des médicaments et réactifs réceptionnés à envoyer au ProVIC National avec copies aux PNLS et PNAM (le délai est 5 jours après chaque réception).
- Des médicaments et réactifs distribués vers les autres CDR à envoyer au ProVIC national avec copies au PNLS et PNAM (mensuel).
- Des médicaments et réactifs distribués vers les structures d'utilisation (CDV, formations sanitaires de la ville de Kinshasa) à envoyer au ProVIC provincial avec copies à la coordination provinciale PNLS et le 3^{ième} Bureau de la Division Provinciale de la Santé (mensuel).
- D'inventaire trimestriel à envoyer au ProVIC national avec copies au PNLS et PNAM (trimestriel).

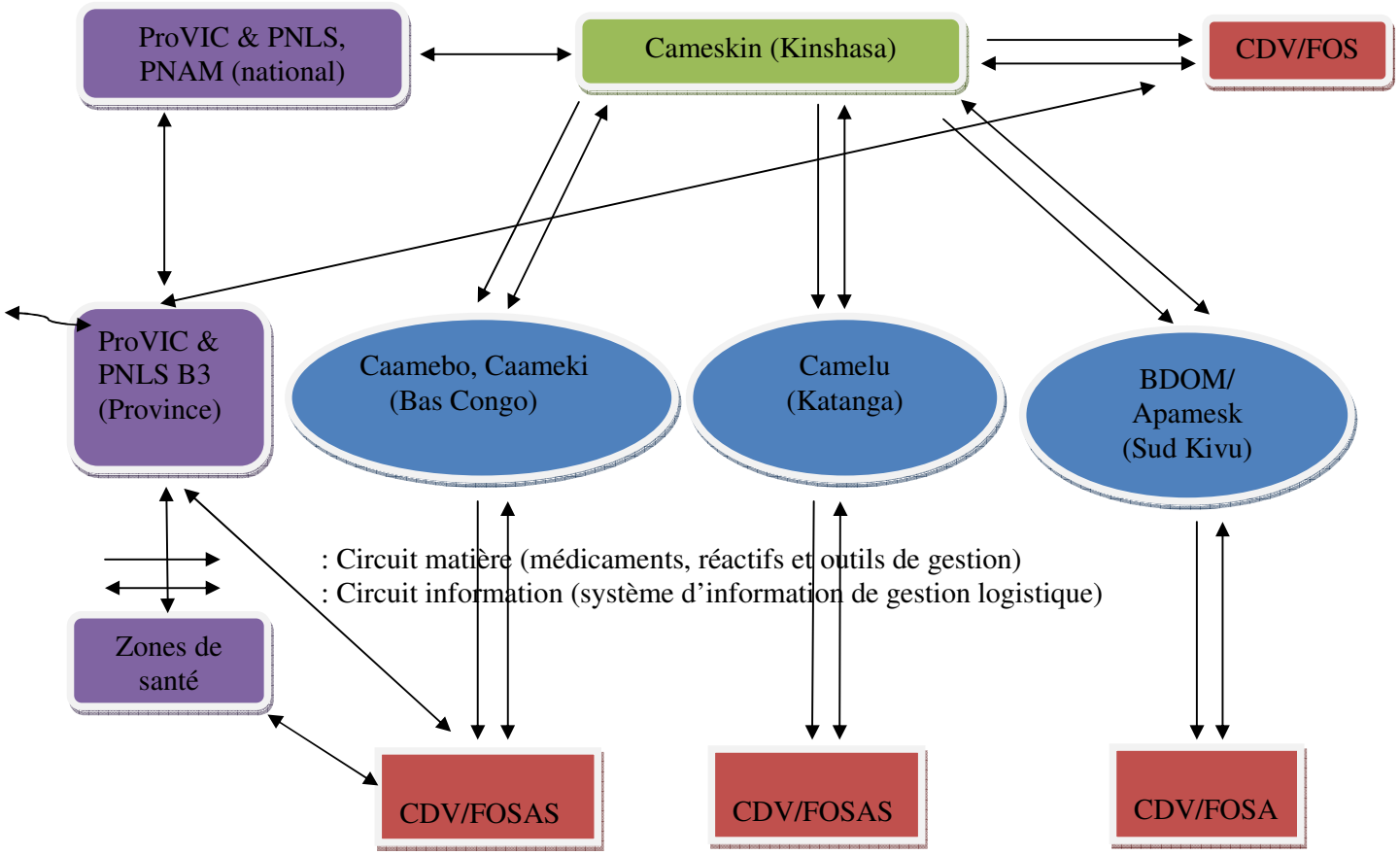
CAMELU, CAAMEBO, CAAMEKI et BDOM/APAMESK produiront 3 rapports:

- Des médicaments et réactifs réceptionnés et provenant de CAMESKIN à envoyer au ProVIC Provincial avec copies à la coordination provinciale PNLS et 3ième Bureau de la DPS (délai de 5 jours après chaque réception).
- Des médicaments et réactifs distribués vers les CDV et formations sanitaires à envoyer au ProVIC provincial avec copies coordination provinciale du PNLS et 3ième Bureau de la DPS.
- D'inventaire trimestriel à envoyer au ProVIC provincial avec copies au ProVIC national, PNLS, PNAM.
- Les CDV et formations sanitaires produiront le rapport mensuel sur base du canevas modèle PNAM. Ce rapport sera envoyé au ProVIC provincial avec copies à la zone de santé. Les CDV et formations devront également utiliser le BON DE COMMANDE modèle PNAM (en cours de révision) pour commander les produits à la CDR.
- Le niveau provincial: ProVIC, PNLS et 3^{ième} Bureau produira un rapport d'analyse de toutes les structures d'utilisation (CDV, fosas) en tenant compte des cibles à atteindre, des cibles atteintes et des stock des produits disponibles, consommations et pertes.

- Le niveau national: ProVIC, PNLS, PNAM fera une analyse des rapports des provinces et des CDR pour évaluer les indicateurs principaux: stock disponible et utilisable dans le circuit, nombre des jours de rupture de stock, taux de perte, risque de péremption.

La rédaction d'une procédure de collecte et transmission de l'information logistique est essentielle pour l'efficacité de la mise en œuvre du projet. Cette procédure devra contenir la description de responsabilité et les délais de transmission des rapports.

Figure 1: Circuit de transmission de l'information



11. La formation

La mise en place de ce système d'information logistique va exiger un renforcement de capacité des niveaux provincial (ProVIC, coordination PNLS, 3ième Bureau) et périphérique particulièrement les prestataires au niveau des CDV et formations sanitaires principalement dans l'utilisation des outils et la maîtrise des estimations des besoins de leurs structures. Il s'agira au niveau intermédiaire de les organiser en équipe capable d'analyser, d'interpréter, de faire un feed back et de prendre des décisions tandis qu'au niveau périphérique; de collecter et transmettre les données logistiques essentielles (Stock Disponible et Utilisable (SDU), Consommation Mensuelle Moyenne (CMM), Mois de Stock Disponibles (MSD), les pertes et ajustements, le Nombre des Jours de Rupture de Stock (NJRS) et la maîtrise de la quantité à commander (QAC). Cette formation devra se faire en atelier, ensuite et surtout sur terrain principalement selon la méthode de supervision formative. Le staff national a bénéficié d'une formation courte de 4 heures le 10/06/2010 sur les éléments de base pour la quantification des besoins en médicaments.

12. Les achats d'urgence du projet

Le projet n'avait pas prévu au départ l'approvisionnement en médicaments et divers autres intrants. Cela a entrainé un décalage entre les différentes activités et la disponibilité des médicaments et réactifs. Le processus d'achat a été lancé mais avec quelques contraintes dont:

- Les quantités des produits à acheter sont faibles et non attrayantes pour les fournisseurs;
- Les conditions de participation au marché des fournisseurs sont rigoureuses par rapport aux aspects de qualité (qualifications produit-fabricant par FDA et OMS, agrément des fournisseurs par les fabricants, autorisations de mise sur le marché en RDC…….) ;
- L'utilisation d'un mélange de deux méthodes d'achat: cotation simple et appel d'offre international restreint qui a allongé les délais des réponses des fournisseurs intéressés;
- Les délais d'obtention des documents d'exonération auprès de l'Ambassade et l'USAID sont longs et non encore parfaitement maîtrisés;
- Le processus de prise de décision pour l'analyse des documents du marché et l'attribution de celui-ci semble long.

Les contacts avec les fournisseurs potentiels a permis d'obtenir les cotations de fournisseurs suivants: CIPLA (Inde), HETERO (Inde), IDA FONDATION (Pays Bas), MEDIPHARM (Kenya), IMRESS (Pays Bas), WAGENIA PHARMA (RDC), MEDICAL GROUP (RDC).

13. Les aspects réglementaires en RDC

L'importation des médicaments et autres produits médicaux est soumise à la réglementation pharmaceutique qui exige que tous les médicaments aient obtenu au préalable des autorisations de mise sur le marché délivrées par la Direction de la Pharmacie, Médicaments et Plantes Médicinales. Pour cette raison le dossier d'appel d'offre pour les marchés futurs doit impérativement intégré cet aspect. En outre à chaque importation, l'importateur doit obtenir des autorisations d'importation des médicaments délivrées par la Direction de la Pharmacie, Médicaments et Plantes Médicinales et pour cela la nécessité pour ProVIC d'être appuyé par un Pharmacien inscrit au tableau de l'Ordre des Pharmaciens qui doit assumer la responsabilité réglementaire par rapport à l'obtention des autorisations réglementaires

(ProVIC peut à ce sujet demander l'appui de MSH qui dispose des pharmaciens). Il est également important de souligner la nécessité de prévoir des activités liées à destruction des produits périmés et hors usage selon la réglementation en vigueur et un budget destiné principalement à la logistique pour la destruction des produits périmés ou hors usage doit être prévu.

14. Les étapes suivantes

- Estimer le poids global et le volume des produits à acquérir en partant du poids et volume des produits achetés pour 6 mois en vue de déterminer les autres coûts prévisionnels (formalité douanière, frais de gestion CDR, coût de transport).
- Estimer les quantités prévisionnelles par site en tenant compte du nombre des cibles par site.
- Elaborer un dossier d'appel d'offre international pour le marché de l'An 2.
- Rédiger un plan d'achat pour l'An 2.
- Déterminer les facteurs de réapprovisionnement au niveau des sites et CDR.
- Former les prestataires des CDV et formations sanitaires ciblées en utilisation des outils de gestion et le calcul des quantités à commander.
- Former les staffs national et provinciaux en logiciel de quantification des besoins (ARV QUANT 2009…..).

Il est **impératif** d'avoir un contrat avec un consultant perlé de profil pharmacien (procurement specialist) pour les aspects réglementaires national et international, l'analyse et interprétation des données logistiques (avec l'unité de suivi-évaluation) de la gestion pharmaceutique et les aspects d'assurance qualité. Il aura pour tâches:

- De produire (adapter) les outils de gestion (collecte et compilation).
- D'appuyer le staff ProVIC national dans réajustements des plans de distribution et les équipes provinciales dans les réallocations intersites et inter provinces.
- D'appuyer le staff ProVIC pour assurer la formation (des prestataires et des responsables provinciaux) sur les aspects essentiels de la gestion des médicaments (estimer les besoins, faire le rapport de gestion, déterminer le facteur de réapprovisionnement, calculer la CMM et la QAC, mesurer le risque de surstock et de sous stock).
- D'appuyer l'équipe nationale à faire une analyse mensuelle 5 jours/mois les 5 premiers mois puis trimestriellement des rapports de gestion des médicaments de 4 provinces.
- De s'assurer du respect de l'assurance qualité sur toute la chaîne (Achats, réception, stockage, utilisation).
- De s'assurer que tous les documents exigés par la réglementation pharmaceutique sont disponibles.
- De suivre et évaluer la qualité de la gestion logistique aux niveaux des CDR et sites
- Documenter les procédures d'obtention des documents d'exonération auprès de l'Ambassade et l'USAID en vue de maitriser les délais de formalités douanières.

Recruter un logisticien (sous la supervision du procurement specialist) dont les tâches consisteront à:

- Obtenir les documents nécessaires au dédouanement des produits.

- Suivre les commandes dans le temps.
- Prendre contact avec les services officiels pour toutes les formalités de dédouanemen.t
- Expédier les produits en province.
- Tenir un tableau de bord des arrivages, des achats locaux et des expéditions des produits.
- Signer les conventions avec les CDR (CAMESKIN, CAAMEBO, CAAMEKI, CAMELU et BDOM/APAMESK) pour la réception, le stockage des produits et la production des rapports.

Conclusion

Le Projet VIH intégré au Congo nous semble avoir des activités d'approvisionnement ayant démarré en retard, ce qui risque d'avoir des répercussions sur les résultats du projet par rapport à l'atteinte des objectifs. Les achats de soudure ayant été opérés dans le domaine des tests de dépistage; la maîtrise de l'information logistique est une urgence pour planifier avec efficacité les approvisionnements futurs sur base d'une historique pour laquelle les efforts à encourager sont fournis par le responsable HTC du projet.

ANNEXE 1: Liste des documents consultés

- Enquête Démographique et Santé en RDC 2007.
- Rapport global de la mission effectuée par le PNUD/FM/PNLS en RDC sur la traçabilité des médicaments, la qualité et l'efficacité de la prise en charge médicale et communautaire des PVVIH, Dr Coportin PNUD/FM 2009.
- Prévention de la transmission du VIH de la mère à l'enfant, draft protocole national PNLS 2010.
- Manuel de gestion de l'approvisionnement dans les structures sanitaires de premier niveau, OMS 2006.
- Cartographie des systèmes d'approvisionnements et de distribution des médicaments et autres produits de santé en RDC, PNAM 2009.
- Un manuel de prévisions pour l'estimation des besoins en contraceptifs, USAID/Projet Deliver 2007.
- Liste Nationale des Médicaments Essentiels version 2010, MSP 2010.
- La Nomenclature PNAM rationalisée 2009, PNAM 2009.
- Guide National de Traitement de l'infection à VIH par les antirétroviraux chez l'adolescent et l'adulte 2008.
- Les Normes et directives en conseil et dépistage volontaire du VIH 2004.
- Le Guide Pratique de Prise en Charge des infections opportunistes et autres pathologies liées à l'infection à VIH en République Démocratique du Congo 2005.
- Guide national de prise en charge des infections sexuellement transmissibles selon l'approche syndromique, PNLS 2006.
- Module de formation des techniciens de laboratoire sur les techniques simples de dépistage/diagnostic de l'infection à VIH et le suivi biologique des personnes vivant avec le VIH, PNLS 2006.
- Module de formation des cadres de HGR en gestion des produits SR, PNSR 2009.

- Evaluation des systèmes de gestion des achats et des stocks de médicaments antirétroviraux en Afrique de l'Ouest et du Centre; OMS/ESTHER/UNICEF; 2008.
- Plan de gestion d'achat et de stock des produits VIH du round 8 Fonds Mondial, CAG/MSP; 2009.

Monique Widyono

Prepared by:	**Monique Widyono**
Trip Dates:	July 4th – July 16th, 2010
Purpose:	To work with the ProVIC technical team to ensure a more thorough analysis of all gender considerations relevant to the DRC context and that specific gender strategies and appropriate monitoring activities are integrated into each component. The work was framed around PEPFAR's five priority areas for addressing gender, and emphasized gender-based violence (GBV) as a key issue.

Background

Gender is a critical component of the ProVIC project, both in terms of ensuring equal access to services and also in terms of contributing to overall project results. Gender-based vulnerabilities to HIV infection affect the design of prevention strategies. Differences in health-seeking behaviors between men and women mean that using a gender lens is critical to designing appropriate activities and achieving targets.

The role of GBV in heightening vulnerability to infection and preventing meaningful access to services is a critical challenge to address. As part of the initial planning process, ProVIC staff identified ways that gender will be integrated into project activities. Further guidance was requested for developing a framework for integration of gender and GBV response and identifying appropriate, specific activities to be incorporated.

Objectives

The objectives of this assignment were to:

- Train ProVIC staff and selected partners in gender analysis and integration of gender related issues into programmatic work.
- Strengthen ProVIC capacity to achieve expected outcomes through incorporation of activities aimed at addressing gender equity and harmful norms that impact prevention, care, support and treatment.
- Identify opportunities for scale-up of GBV efforts, and engage with the PEPFAR team in discussions around specific approaches and activities for addressing SGBV.

Preparatory discussions and assessment of gender issues relevant to ProVIC's work in the DRC

Preparatory work for the STTA included participation in the PEPFAR Consultation on Scaling up the response to GBV, May 6-7, 2010. The aim of the meeting was to identify best practices in combating GBV in order to bring successful interventions to scale. PATH contributed to small group discussions focusing on social mobilization initiatives, highlighting challenges related to social transformation work and examples of initiatives that have shown promise in strengthening community level response to GBV or in changing the norms that underlie its perpetuation.

I also met briefly with DRC HIV/AIDS Advisor, Robert Kolesar. He emphasized the need for a simple tool to monitor unintended negative consequences of ProVIC activities, including

for example, increased violence as a result of economic empowerment work targeted at women.

As part of USAID's IGWG GBV Task Force, I facilitated a brown bag discussion with Mama Muliri, the coordinator of the DRC based GBV program Heal My People, to highlight their work fostering healing and resiliency for survivors of sexual violence. She emphasized the need for women to feel accepted by their communities and families, and the importance of empowering communities to address the factors underlying such violence, including poverty and stigma.

An initial review of data, articles and studies on GBV and HIV in the DRC included:

Bartels SA, Scott JA, Mukwege D, Lipton RI, VanRooyen MJ, Leaning J. Patterns of Sexual Violence in Eastern Democratic Republic of Congo: Reports from Survivors Presenting to Panzi Hospital in 2006. *Conflict and Health.* 2010;4(9).

Central Intelligence Agency. World Factbook for Democratic Republic of Congo. Available at: www.cia.gov/library/publications/the-world-factbook/geos/cg.html. Accessed 6/28/2010\.

Gomez AM, Speizer I. Community-level Intimate Partner Violence and the Circumstances of First Sex Among Young Women from Five African Countries. *Reproductive Health.* 2010;7(11).

Harvard Humanitarian Initiative. *Characterizing Sexual Violence in the Democratic Republic of the Congo: Profiles of Violence, Community Responses, and Implications for the Protection of Women.* Boston: Aug 2009. http://hhi.harvard.edu/images/resources/reports/final%20report%20for%20the%20open%20society%20institute%20-%201.pdf.

Taback N, Painter R, King B. Sexual Violence in the Democratic Republic of the Congo. *JAMA*. 2008; 300(6):653-654.

UNAIDS/WHO. DRC Epidemiological Fact Sheet 2004. http://data.unaids.org/Publications/Fact-Sheets01/demrepcongo_en.pdf.

USAID. Democratic Republic of Congo HIV/AIDS Health Profile for September 2008. www.usaid.gov/our_work/global_health/aids/Countries/africa/congo.html.

Meeting with stakeholders and partners: The first week included meetings with stakeholders and partners with the objective of identifying gender related issues relevant to ProVIC and synergies and opportunities for collaboration, as follows:

1. A formal meeting with the Minister of Gender, Madame Marie-Ange Lukiana Mufankolo and six staff members, including the Secretary General and a PNMLS representative.
2. A discussion with the Director for Women and Development: Ms. Annie Kenda
3. A visit to a center for young vulnerable women in Kinshasa, the Centre D'encadrement pour Femmes Vulnérables and discussion with its Director, Madame Brigitte.

4. A visit to Kimbaseke community, site of a champion community, including the quartiers of Ngiessi, Kamba Mulumba and Luebo and the Biyala Health Zone.
5. A meeting with the Mayor, Pr Edouard A. Gatembo nu-Kake.
6. A visit to SWAA/RDC (Society for Women Against AIDS in Africa), a community based NGO dedicated to identifying and addressing the challenges faced by women in Kimbaseke and a discussion with the president Madaea Aimée Mwadi
7. A discussion with Elsis Mbella, Chief of MONUSCO's Gender Unit; Beatrice Attinger, of the Sexual Violence Section and a representative of the HIV Section.
8. A discussion with Dr Augustin Okende, Director of PNLS
9. A meeting with Dr. Laurent Kapesa and Michelle Russell from the USAID Mission
10. Phone calls with representatives of UNICEF and MDF

Context in the DRC

Studies show that sexual violence perpetrated primarily by armed actors is still being used as a weapon of war, even as a nascent peace is being negotiated. This includes rape of the very young and old, of pregnant women, forced incest, abduction, rape in public and rape with objects. The issue of stigmatization of survivor is an overarching finding of many studies, and one that was reinforced by the experiences of the staff of Heal Africa. One in three survivors report being rejected by their husbands and one in 15 report being rejected by their communities. Women note that the stigma of rape can be as traumatic as the attack itself. Certain populations are particularly vulnerable to social isolation, including women with children born of rape, women with fistula, women who have been gang raped and women testing HIV positive.

Among sexual violence survivors presenting to one hospital, the majority had actually been attached in their own homes, often at night. This is a critical point to make, because exposure to physical and sexual intimate partner violence (IPV) and inequity of power in relationships have been linked to a substantial proportion of new HIV infections in sub-Saharan Africa. Sexual violence in South Kivu is also marked by the predominance of gang rape, increasing the risk of serious injury and the likelihood of STIs. Sexual slavery and prostitution – usually linked to lack of opportunities - are also greatly linked with HIV and STI prevalence in the DRC. Rape of infants linked with "fetishism" has also been identified in the Lubumbashi region.

GBV and SGBV appear to extremely normative in the DRC. The prevalent view, expressed by many at the government and community levels, is that such violence is a deeply ingrained part of Congolese culture that is extremely difficult to change. There appears to be little clarity and understanding about the role and impact of GBV and SGBV on short and long term health and development outcomes for the survivors as well as their partners, families and communities. The quote most often heard is "Why are we even discussing GBV? It has nothing to do with health." Efforts to transform such norms need to be anchored at the community level to have an impact.

The link between GBV, SGBV and HIV risk is especially unclear for many service providers. Little emphasis has been placed on the heightened vulnerability women face to both HIV and GBV and the gender related factors that underlie this vulnerability. Power dynamics in the household and marital relationship, access and control over resources and information,

agency to negotiate safer sex and healthy behaviors, entrenched norms around male and female roles and responsibilities, stigmatizing attitudes and practices on the part of service providers, and structural or systemic discrimination impact risk behavior, access to services and ultimately a woman's ability to promote her own health and the health of her family. The mere fear or threat of violence can act as a powerful barrier to many women who may feel they have no options.

As noted earlier, stigmatization and fear of abandonment, is the major issue for survivors of GBV and women living with HIV. Many survivors, when counseled about PEP after rape, ask "What about how my husband or community will treat me when they know I am on PEP and have been raped? I would rather not have anyone know." Community based initiatives such as Heal My People and SWAA however, have been able to offer the kind of on the ground psychosocial support for survivors that is usually missing in low resource areas, bridging the immense gap between survivors' needs and community attitudes, and fostering understanding and communication. It is important when discussing stigma, to recognize that such attitudes are often directed towards poor, marginalized women who are seen as having no status. Addressing discrimination and stigmatization cannot be done in a vacuum. Emphasis needs to be placed on challenging deep seated beliefs – in tandem with empowering and supporting women, men and entire communities to address the severe economic challenges and limitations they face.

A fundamental challenge is the need to build capacity among service providers to address gender related issues that affect access and use of services, and to identify and respond meaningfully to disclosed or potential GBV and SGBV. The two biggest gaps are in a) lack of standardized protocols and guidelines and training on how to implement them, and b) links with community referral networks and sources of support, including for example initiatives like Heal My People and SWAA (Society for Women against AIDS in Africa). ProVIC staff noted however that training will not address the issue of a delay in treatment kits or the number of trained service providers who elect to leave their communities for better opportunities in Kinshasa or abroad.

Comprehensive action plans for addressing HIV and laws on domestic and sexual violence exist in the DRC. However, implementation remains a serious issue usually linked to the lack of resources. According to the Minister of Gender, many of the laws aimed at promoting human rights and empowering women to address violence are not promoted beyond Kinshasa. Service providers, including at health facilities, police and judges are not aware of their obligations.

A final issue is the lack of commitment on the part of higher level ministers to coordinate work around GBV and SGBV. With the exception of the Minister of Gender, who is spearheading efforts to introduce GBV modules in the education system, promote Maisons de la Femme (Women's houses) and amend discriminatory laws, very little collaboration is being advanced. The Maisons de la Femme provide an interesting opportunity for ProVIC – the concept is to offer women a safe haven that serves as an information and referral center, a source for psychosocial support , and a venue for group education and economic empowerment activities.

Objective 1: Train ProVIC staff and selected partners in gender analysis and integration of gender related issues into programmatic work.

A participatory workshop on gender analysis and integration for HIV/AIDS interventions was offered to staff on Friday July 9th focusing on:

- *Strengthening understanding of the importance and relevance of gender to ProVIC's work*. We used the ecological framework for looking at gender at the individual, relationship, community and structural level, noting that gender operates and impacts all of these levels. We also looked at a framework for integrating gender across the program cycle, including during strategic planning, program implementation, monitoring and evaluation. The major challenge was translating the theoretical understanding of gender into a discussion focusing on its role and impact in our everyday lives and in every aspect of our work. We used a case study around PMTCT to encourage dialogue on how gender affected use of services.
- *Identifying gender related challenges and barriers to prevention, care and support with an emphasis on harmful gender norms and GBV*. We highlighted the critical role of gender as a determinant of health, noting the impact it has on access and control over resources, agency and negotiation within relationships, including over health related practices and behaviors, and access, demand and experiences with services. The major challenge was in identifying very specific, doable activities that could be easily adapted and incorporated into ProVIC.
- *Highlighting promising programmatic strategies for integrating gender considerations and addressing gender related challenges*. We noted the five strategies identified by PEPFAR for integrating gender into HIV/AIDS interventions, namely: Increasing gender equity (in HIV programs); Addressing male norms; Reducing violence and sexual coercion; Increasing income generation for women and girls; and increasing women's legal protection. A major challenge was translating these critical, loosely defined priorities into *doable*, easily adaptable, detailed activities that resonated with the team. We looked at examples of promising interventions– including the OGAC Male Norms Initiative in Ethiopia, Namibia and Tanzania, the IMAGE intervention in South Africa, SASA! and Stepping Stones community engagement work, an initiative by the Liverpool VCT in Nairobi to strengthen health sector wide implementation of standardized protocols guidelines for responding to GBV, and efforts spearheaded by the Latin American InterCambios Alliance in collaboration with PATH, PAHO, the IPPF to train service providers in meaningful care around GBV.
- *Presenting emerging evidence that integrating gender is a potent way to improve overall health outcomes for men, women and children*. Related to the identification of promising strategies was the evidence highlighting positive impact on health outcomes as a result of integrating gender into capacity building, community engagement, awareness raising, and peer to peer education interventions including for example, increased use of prevention and treatment services, improved attitudes around gender equity and GBV, lowered risk behavior and strengthened service provider response.
- *Familiarizing participants with contextually relevant, easy-to-adapt tools and frameworks, including indicators for monitoring, evaluating progress and impact*. The ultimate outcome of the exercise was to offer the team tools that would allow them to identify gender related barriers and gauge progress in addressing them. We highlighted a

few simple tools to guide them in conducting gender analysis: What information do we need? How can we look at the situation at hand and potential interventions using a gender lens? The tools included charts focusing on questions around community level gender norms and experiences as well as service providers' knowledge, attitudes and practices related.

ProVIC participants were very appreciative of the workshop and highly engaged in the discussion. Many noted that it was one of the first truly participatory exercises they had been a part of and the first opportunity they had to grapple with complex and nuanced gender issues. In this sense, the workshop was a success – we were able to delve deeply into how gender and gender norms worked at the family and community level to affect HIV prevention, care and treatment for example.

But gender is not an issue that can be addressed in one session. The challenge for the team remains operationalizing the concepts and the activities highlighted in the workshop. We began by identifying some overall messages and approaches for ProVIC:

- Gender norms, GBV and gender inequity greatly impact access and demand for health services, negotiation and power dynamics in relationships and overall health outcomes.
- Integrating gender is a strong way to improving health outcomes & achieve the highest health standard for women, men and children in all communities.
- It is about the men too – not just the women! In fact it is often more about the men and the need to engage them in addressing norms that lead to increased risk behavior.
- By supporting gender equity and violence free communities, we are supporting increased health outcomes and development for everyone – not just for women. Men are partners with women in supporting health for everyone in the community. When we support equality and equity, women are better equipped, couples are happier and healthier, everyone benefits!
- ProVIC can use the Champion community framework for encouraging increased support for gender equity. ProVIC's message should highlight a Champion communities as one that:
  - Supports the right to full access to services for all members regardless of sex, HIV status or other factors.
  - Respects and treats all its community members equally and equitably.
  - Promotes the full development of all its members – and addresses any challenges or impediments to such development.
  - Does not support violence in any of its manifestations and commits to being proactive in preventing and responding to such violence.
  - Encourages "Champion men" who support equality and speak out against violence.
- Many gender related barriers intersect with other socio-economic factors, including poverty and lack of access to education. Stigmatization of poor and marginalized women for example was raised as a major barrier to HIV prevention and treatment which needs to be addressed.
- Gender norms need to be addressed at the community as well as the service provider level – stigmatizing, discriminatory attitudes and behaviors need to be challenged and transformed into positive, health promoting ones.

- Gender-based violence, including inter-personal violence as well as stranger sexual violence is rooted in deep seated gender norms and power dynamics which need to be challenged at the community level. The responsibility for such violence is *everyone's* responsibility.

The conceptual framework and programmatic tools introduced in the workshop formed the basis for the subsequent in-depth conversations with each of the technical component leads around refining workplans and incorporating activities to strengthen capacity for addressing gender related challenges. (See next section). See Annex A for the presentation and Annex B for the additional list of tools that were shared with the ProVIC team.

Objective 2: Strengthen ProVIC capacity to achieve expected outcomes through incorporation of activities aimed at addressing gender equity and harmful norms that impact prevention, care, support and treatment.

Over the course of the second week, discussions were held with the leaders of each technical component, prevention/HCT, PMTCT, care and support and the BCC/ community engagement specialist, to guide integration of the strategy into specific workplans.

Champion communities

Salva Mulongo and I discussed the potential for using ProVIC's champion communities as the framework for addressing gender and GBV. ProVIC will begin with the overall message that a "Champion Community" is one that:

- Prioritizes meaningful access to services for all community members – without stigmatization – and addresses barriers to access and use at all levels;
- Respects and treats all its community members equally and equitably;
- Promotes the full development of all its members – and addresses any challenges or impediments to such development;
- Does not support violence in any of its manifestations and commits to being proactive in preventing and responding to such violence; and,
- Supports "Champion men" who are "men of quality" that support equality for all.

ProVIC will integrate community engagement and awareness raising activities around gender norms, gender roles, GBV, and stigmatization into already planned sensitization training. Participatory tools including mapping exercises adapted from IHAA, Stepping Stones and PATH will be incorporated into planned workshops to stimulate discussion and action. (See Annex C.) ProVIC will work with community groups such as SWAA in Kimbaseke to identify challenges and illuminate the day to day reality for women - including stigmatization, lack of information, poverty, access to clean water and sanitation, and outline ways to address those challenges. SWAA offers women in Kimbaseke economic empowerment training activities, a small micro-credit lending program, psychosocial support and information relevant to health care, HIV prevention and GBV. It is also important to link service providers with community based groups such as SWAA, or similar ones in other locations, who can support women and OVCs. ProVIC should also link with NGOs such as the UNICEF supported PCPDE to identify and ensure children who are sexually victimized receive treatment and care.

The champion communities could also serve as centers for Maisons de la Femme. Rehabilitation of existing structures could be supported by the Minister of Gender and potentially the Minister of Social Affairs or Monusco. Existing "safe houses" in the DRC are just that – structures. Few resources are focused on integrating activities, training, counseling or services for women – critical components of healing, empowerment and reintegration. ProVIC would link efforts spearheaded by groups such as SWAA and the Maisons de le Femme to offer the kind of holistic support needed by women and OVCs, including building on economic empowerment and training activities and providing information related to HIV prevention and services.

The goal will be to galvanize champion communities that support equitable relationships, prevent all forms of gender based violence and respond meaningfully and holistically to survivors' needs, linking service provision with existing holistic referral networks, care and support groups, empowering women economically and engaging all members of the community including formal and informal leaders, religious leaders, influencers and marginalized women.

HCT/ Prevention

Voulu Mindongo and I discussed the role of HIV testing and counseling as a key entry point for a range of HIV/AIDS services, such as the prevention of HIV, the management of HIV-related illnesses, PMTCT, ART, psychosocial and legal support. Gender inequalities play a critical role in shaping access to and uptake of HIV testing and counseling, including disclosure of HIV status. An HIV test and diagnosis may contribute to additional disadvantage (perceived or real) in women's relationships with their partners, family members and other community members. Fear of negative consequences of testing and disclosure, including stigmatization, abandonment and violence, is a major barrier to the uptake of HIV testing, reflecting the more vulnerable position of women.

ProVIC will integrate specific training modules for service providers and counselors focusing on:

- Clarifying the link between gender norms, GBV and health outcomes including HIV.
- Advising women about the benefits and potential risks of testing, such as discrimination, abandonment or violence by partners or other family members.
- Identifying potential violence and responding to disclosed violence in women's lives.
- Encouraging couples to take advantage of testing and counseling services, while recognizing the potential implications for women, including being blamed for bringing HIV into the household or for being a "loose woman."
- Addressing the potential stigma experienced by women for undergoing an HIV test through working with community based health education and community sensitization, conveying the message that HIV testing is part of a basic package of care.
- Recognizing and avoiding language that reinforces negative stereotypes or prejudices towards clients undergoing testing, including unmarried women and sex workers.
- Ensuring privacy and protecting confidentiality during the consultation, post-test counseling and disclosure of the results. This is particularly important for women who fear violence or other negative outcomes, or who may not have informed their partners about undergoing an HIV test.

- Providing women with pretest information or counseling about HIV, potential risk, risk reduction measures, and preparation for receiving test results.
- Arranging for follow-up counseling, especially through peer counselors or community-based lay counselors and support groups who may be able to give more time to women than clinic-based counselors.
- Ensuring that power dynamics between providers and clients do not undermine the process of informed consent in situations where women are afraid of being denied other health-care services or about being stigmatized, losing their jobs and livelihoods.
- Offering a positive message of health and hope to all clients, regardless of their status.

Training modules and sample protocols adapted from PATH's work with the InterCambios Latin American Network, PAHO, International Planned Parenthood Federation, Medical Research Council and Liverpool Voluntary Counseling and Treatment (Kenya) will be adapted as part of ProVIC's efforts to support enhanced capacity among service providers to address gender and GBV related barriers to HCT and prevention efforts. (See Annex D.)

As highlighted earlier, specific attention will also be placed on linking service providers with community based organizations that can offer women the kind of holistic support frequently missing in clinic based settings.

Care and support

Salomon Rakotovazaha and I discussed gender related challenges relevant to care and support for PLWHA. Women and girls provide the majority of HIV/AIDS-related care, often seen as a continuation of their role as caretakers in families. Much of this work is unpaid and seen as obligatory for female relatives.

Caregivers may not know how to care for sick family members, may not understand how treatment works, and may not know how to support adherence. Moreover, they may not know when follow-up care should be sought from health facilities, nor where to seek such care. Stigmatization also remains a huge issue.

Poor women in households affected by AIDS become even less economically secure. Many have to find water and fuel in order to carry out activities on a daily basis. Many are themselves HIV-positive and receive little or no care or psychosocial support when facing economic hardship, stigmatization and other challenges. Men are traditionally associated with earning income for their families, seldom perform unpaid work and may not feel capable of providing home-based care and support, usually learnt and performed by women. Men are more likely to listen to, accept, discuss and share issues related to HIV/AIDS, including care and support, with other men rather than with women.

Women living with HIV face discrimination and violence because of their sex and their status. Many are blamed for bringing HIV into households, stigmatized for being raped, and abandoned or abandoned by their husbands and communities. Girl OVCs are particularly vulnerable to exploitation, abuse and HIV infection. The vast majority have no access to education or income generating opportunities and struggle to meet their daily needs.

ProVIC will adapt key elements of the framework from the recently implemented AMTIE project for enhancing care and support in Lubumbashi and Matadi regions to complement the existing ProVIC guidelines developed by CRS. In particular, Amitie's community based approach reinforced the capacity of CBOs/FBOs, community leaders, religious leaders, community members and health center staff to address PLHIV and OVC needs in their communities including gender inequities inherent in HIV/AIDS related care and support.

As Amitie operated in two of the four ProVIC regions, it presents a unique opportunity to build on existing networks in the community aimed at supporting women and girls living with HIV and OVCs. The framework emphasized educational assistance for girl OVCs, supporting male home visitors as a way of reducing the burden on women, and addressing women's limited ability to manage or maintain assets with legal assistance to PLWHA and OVCs.

These efforts will be conducted in tandem with community based sensitization activities described earlier aimed at decreasing stigmatization and isolation of people living with HIV and GBV and strengthening support networks that can provide the kind of holistic response to their needs. We have identified a number of activities aimed at engaging men in changing male norms around caregiving and support and empowering them to be "man enough to care."

PMTCT

John Ditekemena and I discussed the gender related challenges to increasing uptake of PMTCT services.

Many women who are tested and found to be eligible to receive ARV prophylaxis medications do not use them because of concerns about the effects of ARVs on their babies, and doubts about the ability of drugs to prevent HIV transmission. Women may not be able to make decisions about taking ARV prophylaxis without the consent of partners and family members, or may not have the time, money or ability to return for further treatment. Women may experience difficulty adhering to ARV prophylaxis because of concerns related to maintaining confidentiality and avoiding inadvertent disclosure of HIV-positive status and the fear of violence, stigma or abandonment. Women have reported discrimination and stigmatizing attitudes on the part of providers as barriers to returning for further treatment. HIV-related stigma in the community remains high and is directed at the person who first tests and discloses his or her status. Because of antenatal testing, more women than men know their HIV status. It has not been uncommon for women who reveal their HIV positive status to be abandoned, and many women fear being abused by their male partners.

Men feel free to make their own decisions about whether to test or not and rarely disclose their HIV status to their partners. However, men are reluctant to use testing sites close to their own communities, fearing lack of confidentiality. The vast majority of men do not get tested and do not know their own status. Both men and women in the community report that health information is supposed to be brought into the family by the man. Women are not regarded as reliable sources of information. Men are viewed as the decision makers in the family. Men regard health care providers as legitimate sources of information, yet they generally do not accompany their partners to family planning, antenatal or postnatal care services and would not be expected to attend the labor or birth of their child. Birth, delivery, and care of infants

are seen as exclusively the responsibility of women. An additional challenge is the availability of medicines and test kits. Even if entire communities are sensitized, if no medicine or kits are available, momentum will be lost.

ProVIC will look at specific modules from the recent Male Norms Initiative in Ethiopia and Namibia, as well as initiatives spearheaded by PATH in collaboration with EngenderHealth and Promundo aimed at engaging men in transforming norms related to health seeking behavior, including use of services. Such initiatives, focused on encouraging peer to peer discussion and group education and awareness-raising have shown promise in increasing uptake of services. (See annex E.) A recent PATH led initiative in Kenya focusing on engaging men in supporting optimal breast feeding practices has also shown great promise in challenging some of the prevailing stereotypes and myths.

As noted in other sections, these efforts will be coordinated in tandem with community based work to reduce stigmatization and address gender norms that impact risk behavior. It will be critical to engage women and men living with HIV, and those who have availed themselves of PMTCT services as champions in their communities. Community based support groups such as SWAA could offer women the information they need regarding risk of transmission from mother to child, potential side effects of medication and benefits of PMTCT.

Objective 3: Identify opportunities for scale-up of GBV efforts, and engage with the PEPFAR team in discussions around specific approaches and activities for addressing SGBV

The original scope of the work for the STTA assignment discussed with ProVIC COTR Laurent Kapesa included the facilitation of a national level meeting aimed at engaging a wide range of stakeholders, and galvanizing awareness and action around GBV, including identification of specific activities to be implemented at provincial and district levels. The meeting was meant to foster commitment on the part of ministers and guide strategic planning around GBV work as a precursor to implementation of the recently launched PEPFAR "GBV scale up initiative."

During a meeting with Dr. Kapesa and Michelle Russell on Friday July 9th, Mbella, Georges and I discussed the possibility of engaging ministers, donors, cooperating agencies and NGOs in a participatory workshop aimed at raising awareness and leveraging the momentum, commitment, resources and "bandwidth" needed to galvanize and implement GBV activities. We envisioned this workshop as a mini follow up to the Washington DC meeting and agreed to consult with DC based colleagues about this proposed activity.

In a subsequent conversation with PEPFAR team members, Heather Davis expressed her interest in supporting such a meeting. Recognizing that significant time and energy would be required, we decided to plan for September or October this year. We envision ProVIC staff contributing as participants, and possibly co-facilitators of the workshop, recognizing that it falls outside the project's current mandate. Additional funding would be required to convene such a meeting - although I have a day left from the STTA that could be dedicated to planning and preparation.

We also reflected more broadly on some findings and lessons emanating from the assignment. highlighting in particular a) the lack of commitment at ministerial level b) the

gap between the legal/policy framework and implementation at community level c) the need to link service provider with community based networks and support groups and d) the need to train service providers on responding meaningfully to potential or disclosed violence. We also discussed the need to focus on interventions beyond provision of PEP, that would address stigmatization faced by women living with HIV and violence. I suggested adding an indicator to measure the number of providers who could refer clients to community based groups such as Heal Africa or SWAA.

Nathalie Albrow and I had a phone conversation with Diana Prieto, Michal Avni, Clint Liveoak and Daniella Ligiero to discuss the proposed national consultation. The question was raised whether such a high level meeting was necessary, what outcomes would be expected, and whether resources might be more effectively leveraged on targeted training for service providers. A follow up conversation was planned with the DRC PEPFAR team.

One issue that needs to be addressed in this context is the current focus on preparing young girls and women to protect themselves from specific incidents of sexual violence, including for example offering martial arts training at community based centers for vulnerable girls. While such training may be empowering for the individual girls, it is not a sustainable intervention and will not have an impact on ProVIC's desired outcomes. I believe the more appropriate approach would be to empower communities to challenge the norms underlying sexual violence and to recognize that it is their collective responsibility to respond to such violence. Empowering young girls to understand that they are not at fault however, is a vital part of this effort.

Anh Thu Hoang

Trip Dates:	September 4-18, 2010
Traveler:	Anh Thu Hoang, PATH
Purpose:	To support the ProVIC M & E team in developing its internal M&E system

Introduction

This M&E STTA was the first trip untaken by PATH's M & E Specialist. This trip took place approximately a month after Ms. Hoang started working on ProVIC. ProVIC has been operational for almost a year; the three regional M & E Specialists have also just started working in the three provinces. This trip was an opportune time to learn directly from the ProVIC M & E team and the technical staff on recent and current M & E efforts.

Trip objectives:

There were a number of trip objectives:

1. Assess ProVIC's current M&E system at the national and regional levels.
2. Finalize tracking tools for each project components.
3. Obtain a more profound understanding of the project's needs in terms of technical support.
4. Support ProVIC's on-going efforts to strengthen national M & E systems.
5. Conduct a workshop on the needs assessment, examining the design, results, and data utilization.

Accomplishments

Assess ProVIC's current M & E system at the national and regional levels
Technical meetings with ProVIC staff

Ms. Hoang met with the technical staff to: 1) fill in gaps of understanding of ProVIC M&E activities to date and 2) obtain their feedback/input regarding current M&E efforts, mainly adapting and refining data collection and reporting tools based on an initial trial perio (See Annex A for list of persons met).

The following are some M&E activities which require M&E technical assistance from Washington and/or support the M & E Team in the DRC:

1. Adaptation of data collection tool for use in **testing mobiles** due to the high volumes of clients.
2. Adaption of data collection and reporting tools for social mobilization**/Champion Communities** to be used by NGOs, communes or health zones, etc.
3. Designing standardized community assessment methodology for **baseline community assessment** for CC.
4. Changing the **PMTCT** tools to reflect WHO policy changes on ARVs
5. **Integration of gender, FP, and TB** into existing data collection and reporting tools

ProVIC M&E work week

Ms. Hoang spent the second week working with the four ProVIC M & E Specialists. The M & E Team met in Kinshasa and not outside of the capital due to a strategic decision to reduce cost. The main tasks of the week were to examine and revise data collection and reporting tools, based on feedback gathered by each M & E Specialist thus far.[5] It was a great opportunity for the entire M & E Team to meet and discuss these issues in person. This was particularly pertinent since there hadn't been follow-up discussions about utilizing these tools after July, when they were initially developed.

In addition, she met with the Kinshasa M & E Specialist, who is responsible for both national and Kinshasa M & E efforts. This meeting helped clarify various M & E issues as she was the first M & E Specialist hired at ProVIC; the meeting provided context to existing M & E-related efforts. Future M & E activities were also discussed, e.g. cascade M & E training for implementing partners.

Finalize tracking tools for each project components

Site visits

The M & E Team and the respective technical coordinators visited two service delivery sites, the Binza Maternity Ward (PMTCT) and a mobile testing site. At the Binza Maternity Ward, the Team spent considerable time going through each step of the process (when a woman first comes into the ward to the end of service provided) to understand the type of information currently collected and examine potential information gaps. (See Annex B for notes of that visit.)

The Team also visited a mobile testing site with PATH's Sr. Program Manager, Nathalie Albrow. Again, the Team examined the currently used data collection tools and the information flow as well as introduced ProVIC's tools. Here, the Team met with the supervisor in charge of that day's operation as well as counselors and other health providers. It was an invaluable visit as the Team got to see for themselves the realities of setting a mobile testing site in a less accessible (to health services) but high-risk community.[6]

Reporting tools

The Team also discussed and refined reporting tools (used by implementing partners, IPs, to report monthly to ProVIC) for each program component. It was a productive exercise since it was revealed that the four M & E Specialists were not using all the reporting tools.[7] For example, one M & E Specialist provided only the table (numbers) reporting tool and not the narrative tool while another person used both. The Team came to an agreement on the reporting tools that the IPs should receive and report back to ProVIC. Moreover, it was also apparent that a monitoring/supervision checklist should be developed for the Team so that everyone does the same thing whenever they visit a site.

[5] During July-September, 2010, each M & E Specialist was supposed to start visiting IP to identify M & E focal points and examine their current monitoring/data collection system, introduce ProVIC's system (data collection and reporting tools). During this period, it was also possible to have already obtained preliminary feedback from either the IP (directly) or via ProVIC's technical coordinators pertaining to ProVIC's tools.

[6] The *quartier* Kingabwa in the commune of Limete is a fishing community.

[7] Two forms, narrative, explaining activities, challenges, and solutions; the other reporting the numbers (targets) reached.

Obtain more profound understanding of the project's needs in terms of technical support

Worked on specific M&E issues

Ms. Hoang also had an opportunity to engage the Team in discussing two important M & E issues: 1) double counting and 2) ensuring data quality at ProVIC. Double counting was recognized as a potential problem and discussed via email. A more in-depth discussion was necessary in Kinshasa; the DC-based M & E Specialist presented ways of reducing double counting at ProVIC. There was also a discussion on indicators that may be problematic, i.e. have different interpretations and applications in the field. (See Annex C for the presentation/discussion.)

Likewise, ensuring data quality is a ProVIC priority. To introduce some main concepts of a routine data quality assessment, a presentation was adapted and translated into French for the Team. Unfortunately, due to time constraints, this discussion was only touched upon only briefly. It was however, emphasized that both avoiding double counting and increasing data quality begin with having a strong ProVIC M & E system, e.g. each person following his/her own operation plan (to conduct monitoring visits etc.) and providing different levels of support to IPs where necessary. For example, an "old" site or partner, where an information system already exists under a previous donor, may not require as much guidance as a new partner who is unlikely to have an established information collection system. (See Annex D for the data quality assurance presentation.)

Set up a communication system between the DRC-Washington, D.C. teams

Seeing the enthusiasm of the M & E Team to learn and discuss M & E issues, i.e. double counting etc., Ms. Hoang suggested that a bi-weekly teleconference take place. It is envisioned that this additional communication channel will create a forum for regular discussions where ideas are exchanged in real time; it does not replace the current email channel. She will also converse with the Kinshasa-based M & E Specialist on a scheduled weekly basis via skype.

Provided inputs into the Champion Community "baseline" assessment efforts

Ms. Hoang and the Community Mobilization Coordinator met with C-Change's Sr. Communication Manager to explore how ProVIC can collaborate (obtain the project information needs) with AED. Dr. Drabo updated ProVIC on the status of C-Change's study. The study protocol had already been submitted to the national ethics review board, it was no longer possible to change the study. Moreover, the C-Change study focuses exclusively on sexual behavior whereas the CC' domain is more general. Thus, ProVIC cannot use the C-Change study as a baseline reading in the Champion Communities. In the end, ProVIC submitted only one question to AED to add to their study, a question pertaining to gender norms and coercive sex. AED will determine whether or not to add ProVIC's question in November once the research firm has been identified.

Support ProVIC's ongoing efforts to strengthen national M&E systems

Participated in MINAS' workshop on harmonizing OVC tools

Ms. Hoang went to Kisantu (Bas Congo) with the Kinshasa-based M & E Specialist and the Health System Strengthening Coordinator to observe the last day of a five-day workshop

which brought together representatives of NGOs, FBOs, and government agencies from all over the DRC to harmonize OVC tools for the DRC. She was quite impressed not only the level of participation and enthusiasm of participants, but also the concrete results of the workshop. (See Annex E for the OVC tools developed.) The accomplishment of the MINAS' work in strengthening its M & E system through partner collaboration was refreshing to see. Based on this observation, she made an appointment with the OVC focal point to learn more about MINAS' vision for M & E-related efforts.

Met with MINAS

Ms. Hoang visited MINAS to talk to Erick Mpiana. The meeting highlighted the importance in providing support to MINAS in its path to having a stronger M & E system, one which renders accurate and timely information to decision-makers. The discussion focused on MINAS' next steps in mainstreaming its M & E system, e.g. developing reporting OVC tools so that implementing partners can more easily provide complete and vital information from field to the national level.

Conduct a workshop on the needs assessment, examining the design, results, and data utilization

Ms. Hoang met individually with all the technical staff (except the CRS Care and Support person) who participated in designing and/or undertaking ProVIC's needs assessment this past year. Initially, she had envisioned a workshop to collectively discuss the methods used and specific results obtained. However, once in Kinshasa, it was apparent that getting everyone together for a half a day was not possible for various reasons. The staff meetings provided adequate key information about the methodology used and confirmed Ms. Hoang's initial assessment of the needs assessment. That is, ProVIC has limited in-house capacity to design and implement research/evaluation activities.

Other

Development of Year 2 Work Plan

Ms. Hoang initiated the annual work plan process with the M & E Team; she continues to work with the Team via email to complete this task.

Met with USAID

Ms. Hoang had an opportunity to go to a meeting with the COP, DCOP, and the Sr. Finance Officer. This meeting addressed USAID's concerns regarding the grantees proposed by ProVIC.

Met with MEASURE Evaluation

She also met with a representative from MEASURE Evaluation who was in Kinshasa to explore potential areas of collaboration between MEASURE Evaluation and ProVIC. Contact information was exchanged; ProVIC will follow up with MEASURE Evaluation concerning the planned future (pilot) research on integrated PMTCT services.

Challenges and issues for follow-up

Finalizing data collection tools: October-November 2010

Finalizing data collection tools for program components requires that each M & E Specialist visits the sites or IPs at least once in order to introduce the tools and examine where the gaps are in order to provide the necessary support. As of the third week of September, not all the sites have been visited once by M & E Specialists in the respective provinces. This means that the IPs did/do not have the ProVIC data collection and reporting tools necessary. Conducting these initial visits is crucial for several reasons: 1) this one of the first steps in developing a ProVIC M & E system; 2) obviously without the necessary tools and support, IPs may or may not provide adequate information to ProVIC; 3) it would be better if the tools are more or less finalized prior to the M & E training to partners in December[8]; and 4) the second year of project implementation has started-- this is a very good reason to have all tools finalized.

It might be helpful for each M&E specialist to develop an **operation plan** detailing the monitoring and supervision visits for the next quarter and follow through with these visits.

Develop monitoring visit checklists for each program: October 2010

The Team should develop a **monitoring visit checklist** for *each* component. During the M&E work week, a checklist was partially created. These checklists should provide the basic minimum of guidelines for all monitoring visits. Ms. Hoang will provide feedback on each checklist developed.

Design the ProVIC M&E training workshop: November- December 2010

Working with the Kinshasa-based M & E Specialist, Ms. Hoang will provide technical assistance in developing a training module detailing ProVIC M & E standards for IPs.

Adapt routine data quality assurance tools: November/December 2010

The sooner that the team understands the basics of routine data quality techniques, the sooner they will be able to apply them. Ms. Hoang will adapt some tools and provide hands-on training if necessary.

Adapt CC tools for ProVIC use: *November 2010*

Using SanteNet CC tools used in Madagascar, she will work with the CC Coordinator in Kinshasa to adapt these tools for ProVIC.

Integrate gender, TB, and FP into data collection/reporting tools: October-November 2010

Working with the team, integrate gender, TB, and FP components into existing tools.

Provide TA in the PMTCT pilot study on Integration of Services: November 2010- 2011

[8] As well as to have understanding of some of the main issues across IPs (gleaned from monitoring visits) and use this information and address concerns for all IPs.

She will also work with the PMTCT Coordinator, providing feedback on the design of the pilot study as well as follow-up once the study takes place. It is envisioned that she will participate in monitoring visit(s) on her next STTA.

Annex A—Persons met

ProVIC	
Mbella Ngongi	COP
George Tumba	DCOP
Daniel Grimshaw	Finance & Administration
John Ditekema	PTMCT
Mitterand Katabuka	Pediatric Care
Voulu Mindogo	Prevention, Counseling and Testing
Salva Munugo	Community Mobilization
Elyse Zambite	Health Systems Strengthening
M&E team	
Denise Ndagano	M & E Specialist, Kinshasa
Venant Zihalirwa Cikobe	M & E Specialist, Sud Kivu
Enoch Nzau Mananga	M & E Specialist, Bas Congo
Antoine Mafwila	M & E Specialist, Katanga
Other	
David Boone	MEASURE Evaluation, JSI
Yaya Drabo	C-Change, AED
Erick Mpiana	MINAS
Dr. Hilaire Mbwoli	Progres Sante Sans Prix
Jose Tchofa	USAID
Robert Kolesar	USAID
Michele Russel	USAID
Charles Zouzoua	Alliance Consultant

Annex B—Rapport sur la descente de l'unite M&E a la maternite de Binza/Kinshasa

Membres de l'équipe ProVIC :

1. Anh Thu, DC M&E Specialist
2. Denise Ndagano, National M&E Specialist
3. Antoine Mafwila, Regional M&E Specialist
4. Venant Zihalirwa, Regional M&E Specialist
5. Enoch Nzau, Regional M&E Specialist
6. Miterrand Katabuka, National Pediatric Specialist

Membres du personnel rencontré

1. Maman Kamyanya, responsable PTME
2. Mr Willy
3. Mr Godefroi
4. Dr Luyeye, Médecin Responsable

Contexte

Le projet VIH intégré au Congo travaillant avec les fonds USAID est opérationnel dans 4 provinces notamment dans la ville-province de Kinshasa ; le Sud Kivu, Katanga et bas Congo. Depuis le mois de juin et avec le recrutement des ME ; les efforts sont fournis pour mettre sur pieds et rendre disponible les outils de collecte des données à toutes les structures d'appui ; lesquelles devraient permettre de collecter des informations satisfaisant aux exigences du projet en matière de collecte de l'info à la base. C'est dans ce cadre qu'un premier atelier avait été tenu à Kinshasa au mois de juillet. Actuellement et avec la visite de suivi évaluation du siège nous sommes allés à la matérnité de Binza pour évaluer la disponibilité et l'utilisation de ces différents outils au niveau de service de PTME.

Objectifs

Général : contribuer à l'amélioration de la qualité du système de suivi évaluation du projet

Spécifiques :

1. Identifier les outils de collecte utilisés à la maternité de Binza.
2. Relever les forces et faiblesses, les contraintes et les difficultés éprouvées de ce service dans l'utilisation de ces différents outils.

Méthodologie

Pour atteindre ces objectifs une visite de terrain en date du 15- 09- 10 par les membres de l'équipe dont les noms sont susmentionnés. Cette visite a consisté essentiellement en un entretien avec les prestataires PTME (voir ci-haut) et en un tour du circuit des clients dans le service PTME.

Activités

1. Entretien général

Avant d'entrer en contact avec le personnel le spécialiste de soins pédiatriques nous a fait un petit briefing sur cette structure en stipulant que Binza est la 2ème maternité de Kinshasa après

Kingasani de part sa fréquence d'accouchements (environs 1000 accouchements par mois). Il ajoute en disant que le programme de la PTME dans cette maternité est appuyé par un projet de l'école de Santé Publique de Kinshasa et que les prestataires ont été recrutés par ce projet ; ce qui crée deux catégories du personnel où d'un coté on a un personnel motivé (salaire du projet) et de l'autre un personnel habituel de la structure qui n'est pas motivé par le projet : un challenge pour la structure.

Après ce briefing nous avons été accueilli par le personnel impliqué dans le programme PTME avec lequel nous eu une petite séance de présentation.

2. Visite des services

Conduit par le responsable de la PTME (Ecole de Sante Publique), l'équipe a fait le tour complet de tous les services de la structure en suivant le circuit des femmes dans le cadre de la PTME. A chaque étape les prestataires ont expliqué la procédure de travail et les outils utilisés ; les membres de l'équipe ont posé des questions d'éclaircissement et ont donné des observations d'amélioration soit de la qualité des services soit de l'utilisation des outils.

Circuit de la PTME à la maternité de Binza

1. *Salle d'animation sanitaire.* Dans cette salle les femmes sont accueillies et prennent part à une séance d'éducation sanitaire sur les thèmes diversifiés y compris celui de la PTME. C'est au cours de cette séance qu'on explique à toutes les femmes la nécessité de connaître leur statut VIH.. Puis on remet un jeton à chaque nouveau cas pour l'achat de la fiche de la CPN.
2. *Caisse.* Les femmes se dirigent à la caisse pour acheter la fiche moyennant 6500FC (7,2$)
3. *Remplissage de la fiche de CPN*
4. *Prélèvement des signes vitaux*
5. *Prélèvement sanguin pour le dépistage.* Les femmes se dirigent dans un boxe où elles sont prélevées pour le dépistage du VIH. Les échantillons prélevés sont envoyés au laboratoire du Centre de Santé pour les tests rapides et les résultats sont rétournés au conseillers pour le counselling post-test.
6. *Consultation prénatale.* Les femmes sont reçues une à une dans une salle où elles sont examinées (examen clinique ; manœuvre de Léopold). C'est ici où nous avons trouvé **le registre de la CPN.**
7. *Vaccination et prise des médicaments.* Les femmes sont reçue dans une salle où elles sont vaccinées(VAT) et reçoivent quelques médicaments notamment le fansidar, l'acide folique, le fer.
8. *Salle d'attente.* Après avoir reçu le vaccin et les médicaments, la femme attend dans la grande salle.
9. *Salle intégrale PTME.* Les femmes sont reçues dans une salle où un prestataire leur donne un message spécifique PTME.
10. *Post-test.* Les femmes sont reçues une à une par un prestataire pour recevoir le résultat du test de dépistage VIH. Ici lorsque la femme est positive le prestataire lui remet une dose de nevirapine pour elle et pour sont bébé qu'elle pourra prendre avant l'accouchement.

Ici nous avons trouvé entre autre outils:

- Le registre de prélèvement des femmes enceintes

- Le registre de prélèvement des partenaires masculins
- Le registre des femmes VIH positives
- Le registre de référence pour la prise en charge médicale
- Registre de suivi des enfants exposés
- Registre des résultats
- Fiche de visite à domicile (pour l'enfant)

Noter que ces registres sont gardés dans une étagère à clé.

11. *Sortie.* La sortie de la femme après le post-test se fait par une porte autre que celle de l'entrée.
12. *La maternité. L*a femme enceinte vient accoucher ; si elle séropositive l'infirmière accoucheuse se réfère à un code conventionnel se trouvant sur la fiche (66/…. ; 22/… ;... 11/…).

    Ici on a comme outils :

    - La fiche d'accouchement.
    - Le registre de prélèvement pour les femmes qui ne sont pas passées par la CPN de la maternité.
13. *Sortie de la maternité*. A la sortie de la maternité la femme est conviée de rentrer dans les 45 jours pour le prélèvement de l'enfant.
14. *Prélèvement de l'enfant*. L'enfant revient après 45 jours ou 6 semaines pour être prélevé sur papier buvard et l'échantillon est transféré au laboratoire de recherche du PNLS pour le diagnostic précoce (Test PCR). Ce rendez-vous correspond exactement à la première séance de la CPS, ce qui faciliterait le traçage des enfants ; mais il faudra alors que les mères obéissent à ce rendez-vous.
15. *La prise en charge médicale de la femme séropositive*. La femme est reçue au centre de santé (dans la même structure) pour recevoir les ARV après avoir fait le test des CD4 à Kingasani.

    Ici on a le registre et la fiche de traitement ARV.

Observations

Points forts

- Circuit des femmes enceintes au moment de la PTME est conforme aux normes de la PTME.
- Tous les outils sont disponibles.
- Les outils sont bien tenus.
- Les prestataires sont enthousiastes.
- Les prestataires connaissent leur travail.

Points faibles

- Pas de référence pour l'accompagnement psychosocial des femmes séropositives.
- Les femmes dont les résultats sont indéterminés sont apparemment perdues de vue.

Les recommandations faites

- Référer à AMOCONGO les femmes séropositives pour l'accompagnement psychosocial.
- Allez rechercher l'enfant si la mère ne l'a pas amené au premier rendez-vous pour le prélèvement.
- Se rassurer que les femmes avec un résultat indéterminé sont ré-prélevées à la maternité.
- Inciter les femmes séropositives à faires aussi le dépistage de la tuberculose.
- Ajouter une colonne fonction ou occupation dans le registre des maris.

Charles Zouzoua

Trip Dates:	September 11-30, 2010
Traveler:	Dr. Charles Zouzoua, Consultant
Purpose:	To support the ProVIC team in coordinating with partners to identify priorities, and to develop a capacity building plan for addressing identified needs at provincial level.

Introduction

Strengthening the capacity of government, civil society, and communities to deliver quality HIV/AIDS services is one of the core strategies of PROVIC. It will achieve this essential element by reaching existing successful local organizations, identifying new ones and assessing gaps in skills, knowledge, practices and determine what is needed to strengthen coordination, monitoring, supervision, data-collection, analysis and utilization at the provincial level.

Purpose

To support the ProVIC team in coordinating with partners to identify priorities and to develop a capacity building plan for addressing identified needs at provincial level. More specifically, the objectives were are follows:

1. Assist the project to prioritize key interventions that are needed to help the provincial governments fulfil their mandates in coordinating and monitoring HIV/AIDS and OVC related activities, and ensuring proper data collection, reporting and management.
2. Assist provincial governments across the project regions to engage more effectively with services providers, services delivery points and communities in order to deliver high quality HIV/AIDS and OVC services.
3. Understand the areas where provincial capacity is weak to more effectively ensure linkages between services delivery points and communities.
4. Increase the capacity of community based organizations and other implementing agencies to design and provide integrated, quality and sustainable services.

Below are the key deliverables expected from this assignment:

- Analysis of the capacity gap data at provincial level.
- Capacity Assessment Tools developed for NGOs and health care facilities.
- Capacity building plan developed and approved by stakeholders (including recommendations on how provincial government can link more effectively with the Champion Community Engagement model).
- Completed trip report containing all research data, tools, and analyses.

Methodology

To analyze the capacity gap data already identified and the set of methodologies used combined, as follows:

- Content analysis including transcription, coding and data processing.
- Results interpretation, also taking into account:
  - Individual and/or group discussions with ProVIC team, some key partners and stakeholders from Kinshasa and Matadi.
  - A desk review.

These methodologies were summarized in a tool (Grid) which can be found in the Appendix 5 of Attachment A.

Priorities identified during the capacity gaps analysis were used to develop the capacity-building action plan for provincial governments.

Accomplishments and deliverables

1. Summary of provincial government capacity assessment findings

Prior to the capacity gap analysis of Provincial governments, capacity assessments were conducted in the 4 ProVIC-focused provinces: Bas Congo, Katanga, Kinshasa, and Sud Kivu.

- The capacity assessment process started in April 2010 with the filling of the assessment grid (Appendix 1 to 4 of Attachment A) conducted by the ProVIC technical team. The coordinating bodies assessed are the followings: National AIDS Control Program (PNLS), Social Affairs Division (DIVAS), and Gender & Family Division (DGF). A total of nine (9) provincial HIV coordinating bodies were assessed: 3 in Bas Congo and Katanga (PNLS, DIVAS and DGF), 2 in Kinshasa (PNLS and DIVAS), and 1 in Sud Kivu (PNLS).
- Technical areas assessed were: Planning, Coordination, Monitoring & Evaluation, Financial Management, and Administration & Human Resources Management.

Main findings of the provincial government capacity assessment

Below are summarized the provincial government capacity gaps identified.

Planning

Just over fifty-five per cent of the provincial government HIV coordinating bodies (5/9) assessed have operational action plans, but they do not have planning sessions to follow up plans (PNLS in Bas Congo, Kinshasa, and Sud Kivu ; and DIVAS in Bas Congo). Everywhere, resources are not available for the functioning of coordinating bodies.

Coordination

All coordinating bodies have a weak capacity in coordination, particularly with regard to community care and support interventions.

Monitoring and evaluation

Just over 55 percent of provincial government HIV coordination bodies do not have M&E plans. The provincial governments with M&E plans (PNLS in Bas Congo, Kinshasa and Sud Kivu; and DIVAS in Kinshasa) are not using them effectively. In addition, data collection tools are not standardized (particularly for DIVAS in Bas Congo and Kinshasa ; and DGF in Bas Congo).

Financial management

Some provincial government bodies have a bank account (PNLS in Bas Congo and Katanga ; DIVAS in Kinshasa and Katanga; and DGF in Bas Congo) while others do not yet have one (PNLS in Kinshasa and Sud Kivu; DIVAS in Bas Congo and DGF in Katanga). Generally, the financial management is of medium quality however some best practices cases exist (DIVAS in Kinshasa and Katanga; and PNLS in Bas Congo).

Administration a human resources

Commonly, a formal induction process exists and all staff are inducted. Regulations, policies and procedures are available and well known in some of provincial coordinating bodies (DIVAS and DGF Katanga), while others (such as PNLS Katanga) do not yet have them.

2. Main findings of the gap analysis

General comments

- 12 coordinating bodies should be assessed (3 by province). 9 out of the 12 were assessed. The reason for not assessing the 3 others was due to the unavailability of the respective managers.
- As it coordinates health care provision within the province, the "Inspection provinciale de la santé" should be assessed, as well as the "Comité National Multisectoriel de Lutte contre le Sida (CNMLS)" since the later is in charge of the multi-sectorial coordination of the fight against HIV at national and provincial level.

Findings

- Provincial coordinating bodies have capacity gaps in all the management areas assessed, however the capacity gaps vary from one coordinating body to another.
- Globally, the capacity gaps identified are in the following descending order of importance: coordination, planning, M&E, administration and human resources, and financial management.
- When comparing HIV coordinating bodies capacity gaps within each province, the results are as follows:
    - In Bas Congo province: The PNLS has less serious capacity gaps than DIVAS and DGF. DGF has a weak capacity in coordination, planning, M&E and HR, while DIVAS is weak in financial management and M&E.

- In Katanga, the DGF has weak capacity in all management areas except in HR, while DIVAS has problems in planning and M&E. The PNLS main capacity gaps are focused on HR management.
- In Sud Kivu province, the PNLS capacity weakness is in financial management and HR.
- In Kinshasa, the DIVAS has weak capacities in planning and M&E, while PNLS gets weak capacities in all management areas except in planning.

- The Provincial government capacity gaps identified are part of the global weakness of the health system including the fight against HIV in DRC, as noticed in (i) meetings/ discussions we had with key partners and stakeholders, and (ii) review of existing documents.

Problems linked to the long period of emergency situation

The emergency situations occurred in the country have disorganized the health system which suffered the consequences of (i) the replacement of health care settings by NGOs, (ii) the set up of parallel pharmaceutical supply chains, (iii) the set up of many health information systems. All these consequences reflect some of the management issues (planning, M&E) identified during the provincial government capacity assessment.

Lack of the health ministry leadership

The constant decrease of the budget devoted to health has lead to the loss of the Ministry of Health autonomy in making decision, and guiding the national health policy.

Human resources

The lack of employees' motivation has led (in a logical way of support provided for specific interventions) to the set up of merit bonus and other payment method such as perdiem. Indeed poor salaries has created a high turn over of staff who continuously look for the «highest bidder».

Involvement of communities

One of the main ideas in community participation is that people should have something to say on services provided to them. This is far away, though people contribute at around 70% in health zones functioning fixed charges.

Donors in the health system evolution

Some external partners (financial and technical partners) are not always committed to sustain the development of the health system. Among the problems raised by their practices, the followings can be pointed out: (i) increasing number of conflicts between donors and implementing partners, (ii) accentuation of the verticality of their interventions which are not integrated into the national health system.

In summary, the priority needs defined by the health authorities meet the findings of the provincial government capacity gaps analysis. These needs are related to (i) the revitalization of the health zone, and the correction of the bias occurred, (ii) the strengthening of governance and leadership, (iii) the development of human resources in the

health sector, and (iv) the Health financing reform. Based on these priorities, the capacity-building action plan has been developed.

Key recommendations

Recommendations are made to the CPMLS (Provincial Multisectorial Committee for the fight against Aids) and ProVIC to :

- Complete the capacity assessment in the 4 ProVIC-focused provinces by adding other coordinating bodies such as PNMLS and « Inspection Provinciale de la Santé ».
- Extend the assessment to other provincial stakeholders involved in activities supported by ProVIC:
  - Health care settings providing services in the project targeted health zones.
  - Member organizations (NGOs), and Champion Community pilotage committee.
- Conduct periodical assessments (every 2 years) to measure progress made by provincial government along with the capacity building implementation plan
- Restitute to provincial governments, the assessment and gap analysis results for a better understanding and appropriation of the capacity building plan developed for them to overcome the capacity gaps identified.

3. Capacity-building plan developed

Including recommendations on how provincial government can link more effectively with the Champion Community model.

Key priorities for capacity-building

The capacity gaps analysis conducted, meetings held with provincial governments' representatives, as well as partners and stakeholders including community-based organizations, have allowed us to determine key priorities for capacity building action plan: (i) the revitalization of the health zone, and the correction of the bias occurred, (ii) the strengthening of governance and leadership, (iii) the development of human resources in the health sector, and (iv) the Health financing reform.

The proposed action plan is part of a practical and participative process which has already defined (through the capacity assessment exercise and capacity gaps analysis) the priority needs and actions required to overcome the identified capacity gaps which impede the provincial HIV coordinating bodies interventions.

Capacity-building plan and the "Three Ones" principle

As ProVIC contributes to the national response to the HIV epidemic, it is expected that the current capacity building action plan, which is part of ProVIC interventions related to the Health System Strengthening, fit in the DRC 2010-2014 National Strategic Plan, in concordance with the "Three One's" principle.

More specifically, the capacity building action plan fits in the strategic axis # 4 of the National Strategic Plan: "Support to the implementation of the National Strategic Plan".

The general objective of the capacity-building plan is to contribute to the support for the implementation of the National Strategic Plan in the 4 ProVIC-focused provinces.

Areas of Priority Action

Relying on the National Strategic Plan, 5 areas of priority interventions have been identified:

- Area of Priority Action 1: Strengthening community involvement.
- Area of Priority Action 2: Strengthening coordination frame.
- Area of Priority Action 3: Sustainable financing of the fight against HIV.
- Area of Priority Action 4: Improving resources management.
- Area of Priority Action 5: Production and management of strategic information.

For each area, strategic objectives, expected results, strategies and activities are described in the capacity building plan technical report (See attachment B). In addition, performance indicators and activities costs have been written down.

Key recommendations

Recommendations are made to the provincial governments (governors and ministers) and the provincial multi-sectorial coordinating body (CPMLS):

To provincial governments (governors and ministers)

- Take the leadership of the fight against HIV/Aids, by supporting the coordinating bodies' activities.
- Harmonize and disseminate human resources & financial management tools.
- Standardize the procedures and practices of employees motivation in the public sector.
- Enhance regular experience sharing opportunities among provincial ministries staff on best practices in the area of management.

Provincial government can link more effectively with the Champion Community model through the following actions:

- Strengthen the leadership of the provincial multi-sectorial coordinating body (CPMLS) by putting the Champion Community engagement model implementation steps and activities under the CPMLS legal entity. It means that the Champion Community must collaborate more closely and establish permanent communication line with the CPMLS and the other sectorial HIV coordinating bodies (PNLS, DIVAS, DGF, etc.) depending on the support needed to implement activities (Prevention; Care & support: psychosocial support, economic support, etc.). To this effect, a communication focal person can be appointed within the Champion Community management team.
- With the support of the provincial/local multi-sectorial committee for the fight against HIV, Champion Community management team should promote Champion Community engagement model towards partners, stakeholders, local governments to replicate/extend the model.
- ProVIC should strengthen the Champion Community management team (pilot committee) capacity in coordinating both Champion Community members common and individual activities. For common activities, there is a need for management team to have

an office space with minimum equipment and a financial support for transportation, communication and administrative needs.

- Provincial/local multi-sectorial committee should involve the Champion Community management team in the provincial/local coordination meetings and other activities linked to Champion Community areas of interventions.

To CPMLS (as the provincial HIV multi-sectorial coordinating body)

- Insert the current Capacity Building action plan into the national/provincial technical support plan of the 2010-2014 National Strategic Plan.
- At the 4 provincial ProVIC sites, where governments capacities have been assessed, and a capacity-building plan proposed:
  - Set up a **steering committee** to manage the capacity building plan.
  - **Appoint a technical support focal person** within the CPMLS.
  - **Validate** the capacity building plan.
  - Integrate the provincial capacity building plan into the provincial HIV operational plan to be developed after the National Strategic Planning.

Next steps

- ProVIC management team has to **restitute to provincial governments, the assessment and gap analysis results** for a better understanding and appropriation of the capacity building plan developed for them to overcome the capacity gaps identified.
- In each of the 4 provinces, provincial government HIV coordinating bodies (PNMLS, PNLS, DIVAS, DGF) should **review and validate the capacity-building action plan.**

ProVIC Consortium Partners

Travelers: Nathalie Albrow, PATH Senior Program Manager (September 12-24, 2010); Kathryn Goldman, Chemonics Project Director (September 19-October 1, 2010); Simon Mollison, Head, Contracts and Agreements Team, International HIV/AIDS Alliance (September 18-29, 2010); Gabrielle Bielen, Elisabeth Glaser Pediatric AIDS Foundation (September 19-29, 2010)

Purpose: Work planning, annual report development, and project oversight.

Introduction

Both the Year 2 work plan and the Year 1 annual report are due to USAID at the end of the month of October. This presented the consortium with an excellent opportunity to come together and evaluate how the project has performed this year, what improvements need to be made, and which goals, activities, and targets should be set for Year 2. Consortium participation in the evaluation and work planning process is critical to ensuring full partner buy-in and coordination on all selected approaches. In addition, it streamlines the process of gathering input and ensuring all partners' approaches are incorporated. With the need to rethink the grants strategy, more fully launch champion communities, and transition from CRS to the International HIV/AIDS Alliance, this was a particularly important year for planning.

Trip objectives

- Evaluate project progress in Year 1 as a foundation for preparation of the annual report.
- Generate the content for the Year 2 work plan.
- Agree on targets for Year 2 and update the PMEP.
- Provide supervision and technical support to project staff.

Accomplishments for all consortium representatives

Year 2 work planning workshop

The Year 2 planning workshop took place from September 20-24, 2010 in Kinshasa and included the full technical team from Kinshasa, representatives from the regional offices, and the four consortium representatives named above. The workshop included team-building sessions, as well as analysis of Year 1 from a technical and management perspective to determine lessons learned and changes or improvements that could be made. In addition, we discussed the overall project strategy and results and how to do more to integrate the Champion Community model across all components for improved sustainability and innovation in the project.

The team heard presentations from USAID staff, and each consortium member supported their respective technical staff in developing presentations that outlined their overall strategy and approach, accomplishments in Year 1, planned activities for Year 2, and expected results in terms of targets for the PMEP. Each component was discussed by the full team, and participants were given the opportunity to discuss the details of implementation. The team devoted particular time to discussing how to accelerate the implementation of the Champion

Community approach and how to integrate this approach with all other components. Sessions were also devoted to discussing project M&E and the development of updated targets for Year 2 and Year 3, project finance and budgeting practices, and next steps on the grants process. Regional coordinators presented the situation in their regions and facilitated a discussion among participants of the best strategy moving forward in terms of final grantee selection that responds to the criteria established by the team of finding fewer partners per region who have the capacity to do multiple interventions, particularly using community mobilization as a base. Following the work hop, staff worked with their respective consortium partners in developing their work plans, revised M&E targets, and budgets.

Nathalie Albrow (PATH)

Overall project supervision

Ms. Albrow had meetings and consultations with the COP, DCOP, and finance and administration specialist to discuss a number of pending issues on the project and determine resolutions. These included discussions of the project targets and implications on the budget, grants strategy, procurement of commodities, and other general communications. Ms. Albrow also met with PATH staff (Kinshasa and regional M&E specialists, the grants accountant, and finance/admin specialist) to discuss how things are going programmatically, identify any human resources, management or technical issues they are having, and clarify any questions. She provided a brief overview of PATH to the new regional M&E staff and explained their respective roles within the consortium and how the Chemonics/EGPAF/Alliance (and CRS) partnerships were conceived. She also participated in some of the M&E discussions, as the team began to flesh out their anticipated activities for Year 2.

Ms. Albrow also met with Michelle Russell and Robert Kolesar from USAID, along with project consortium partners (Ms. Goldman from Chemonics, Ms. Bielen from EGPAF, and Mr. Mollison from IHAA), to discuss how the project is going and raise issues that require immediate attention.

Commodities

Ms. Albrow held meetings with ProVIC's pharmaceutical procurement consultant, MSH, and PNMLS to discuss some of the project's procurement issues and identify potential partnerships to help us address some of the challenges the project currently faces with the commodities situation. These meetings are further described below.

Pharmaceutical procurement consultant

Ms. Albrow met with pharmaceutical procurement specialist, Mr. Frank Biayi, to discuss the work he had done while consulting for ProVIC, and review some of his recommendations. They reviewed the quantification and cost information he had provided and the methodology used for vendor selection to better understand why this process had taken so much time. Most pertinent for future planning was his outlining of the processes and logistics involved following actual procurement for storage and distribution of the commodities, and consequently the necessary resources required. Indeed, if ProVIC is to continue to be required to procure and distribute pharmaceuticals (ARVs, test kits, cotrimoxazole, and associated supplies), we will need additional resources to manage this process. We will need to modify the budget to plan sufficient funds to purchase these commodities, and must also factor the *cout d'approche*, which essentially are all the associated charges (taxes, handling,

storage, etc.) factored in from the moment the pharmaceuticals reach customs in Kinshasa to the point where they reach the health facility or beneficiary. According to Mr. Biayi, these charges can add another 40 percent to the total cost of commodities. Further, given the volume of supplies we are examining, managing their distribution will likely necessitate having a pharmacist logistician on staff. We may consider perhaps cost-sharing this position with another project (e.g., the MSH-led Strengthening Pharmaceutical Systems (SPS) project or the upcoming TB project) if these needs are not full-time. Needless to say, all options will be explored and discussed with USAID.

PNMLS

Ms. Albrow also met with PNMLS to discuss the possibility of obtaining ARVs from them while we await USAID approval to procure ARVs for our PMTCT component. The outcome of the meeting was successful, and we received a commitment from PLMLS to provide us with an immediate, six-month supply of ARVs to carry us through the current gap period. This news brought great relief, since our anticipated shipment of ARVs and cotri from IDA in the Netherlands, could take several weeks upon approval, and since customs clearance may also cause further delays (judging on past experience).

The HIV/AIDS lead at the Ministry of Health, Mr. Freddy, joined the latter part of the meeting, and we extensively discussed gender, and specifically GBV issues, in the DRC.

MSH

Ms. Albrow met with SPS project staff to better understand their role in supporting the AXxes project with the distribution of essential drugs. They described how this collaboration works, and then we explored possibilities for a similar collaboration with ProVIC—given that ProVIC has also been tasked with the procurement and distribution of pharmaceuticals, yet we do not have the in-house expertise to do this at a large scale. SPS felt they could best support ProVIC via provision of technical assistance to train agents working at the *depots centrale* (central storage and distribution centers) in transparent management and distribution, and in accurate reporting to avoid overstocking drugs (that will then expire) or stockouts.

Grants

Ms. Albrow had several meetings with the COP, DCOP, and finance/administrative specialist to discuss the current grants situation and propose a revised grants strategy which a) incorporates the Champion Community approach, and b) reduces the total number of partners. The grants strategy was then presented to the technical team during work planning. This provided the opportunity for an animated discussion as the team worked to identify a short list of prospective grantees from the more than 30 organizations originally proposed to USAID. Regional coordinators, technical specialists, and management/leadership staff all weighed in to help gauge which of the prospective grantees would be best equipped to support our activities within the CC context.

Annual report and work plan

In addition to participating in the week-long work planning workshop by steering discussions and actively engaging with the project team to thoughtfully plan Year 2 activities, Ms. Albrow also worked with ProVIC staff to begin developing the annual report. She gave a

brief training on how to write success stories and provided tips and strategies for capturing information and results in a compelling manner.

Site visits

Ms. Albrow accompanied the M&E team and HCT specialist to visit a mobile testing site in the *quartier* Kingabwa of the Limete commune, a fishing community. She met with the supervisor of operations, as well as counselors and other health providers, to discuss logistics of managing mobile HCT units, its benefits, and challenges. This was an invaluable visit to see the realities of setting a mobile testing site in a less accessible (i.e., to health services) but high-risk community.

Ms. Albrow accompanied COP, Mbella Ngoni, to visit the Centre Pediatric de Kimbondo, an orphanage center that has applied for ProVIC funding to incorporate HCT activities into their clinic—which is used not only by the inhabitants of the Kimbondo Center, but also by members of the larger community given the quality of services it aims to provide.

Challenges and issues for follow-up

Grants

Ms. Albrow laid out multiple follow-up steps prior to her departure to keep the grants process moving forward, such as:

- Draft communications to send to all grant applicants on where the process currently stands, and the programmatic shift to include the champion community approach in their activities.
- Finalize a shortlist of 'preselected' organizations we expect could implement integrated activities within the Champion Communities model and who therefore would be most strategic to work with.
- Bring all grants managers up to speed on what was discussed during the workplan with regards to grants, and the shift in our approach following discussions with USAID (i.e. aiming to fund 8-10 larger grants total, need to ensure Champion Communities incorporated into the scope, all activities in prevention and care & support to be conducted within the selected sites/zones of intervention, focus more on a holistic/integrated approach etc).
- Amend the RFA to include the champion communities SOW. This will be re-submitted to the shortlisted orgs along with the communication re-programmatic shift (referred to in 1) which explained why we are asking orgs to rethink their plan, and resubmit a new application.
- Follow-up on OVC's and PLWHA who received care and support via FHI & subsequently our bridge grants. Contact the bridge grantees and ask about the status of each recipient. We need to minimize the potential gaps in services during this interim period before we have awarded grants in place.

Commodities

As mentioned in greater detail above, there is a lot to resolve with regards to the commodities issue and this will be a top priority in the months ahead. We need to determine whether ProVIC will continue to purchase the pharmaceuticals needed for project activities or whether

the project will be able to leverage these from other donors. If we are responsible for purchasing these, we will need to modify the procurement budget, and plan for adequate resources to support the supply chain/distribution management process. We must also continue to explore areas for collaboration with projects, such as SPS, among others, to make sure we are capitalizing on all possible synergies to create cost, logistical and programmatic efficiencies.

Project budget realignment

In response to a suggestion from USAID to seek areas where monies could be saved and re-programmed to support direct implementation activities in the field, we have been working realigning the budget, and have identified enough savings to realign close to $3m to direct in-country implementation activities (approximately $1m will go to in-country training, and $2m will be reallocated to the grants fund). We expect to submit a formal request for modification shortly.

Kathryn Goldman (Chemonics)

Technical support to work planning for HCT and champion communities

Ms. Goldman worked with the HCT specialist and community mobilization specialist in developing their respective year two work plans including the strategy, activities, and milestones; in setting targets for year two based on the project budget and partner capacity; and in brainstorming for the annual report and associated success stories to be developed.

Overall project supervision

As Chemonics has such a significant technical role on the project, Ms. Goldman also conducted general supervision tasks such as meeting with USAID on three occasions- once during the first week with the entire consortium to discuss project status, once with the COP to meet the new USAID staff, and once alone with outgoing and incoming USAID staff to debrief the trip overall. Ms. Goldman also met with most of the project staff to discuss how things are going technically and in terms of project management, to understand any issues they are having, and to clarify any questions they may have. Ms. Goldman then met with both the COP and the DCOP to provide performance feedback to them and suggest areas for improvement.

Development of a SAF budget

Ms. Goldman also worked with the DCOP and the technical team to develop a year two budget for project activities, in particular budgets for each technical component that included their grants, training, and procurement budgets. These budgets helped the project determine the feasibility of the targets to be established for the PEPFAR Country Operational Plan.

Challenges and issues for follow-up

Accelerated implementation of champion communities

Implementation of champion communities was somewhat delayed in the first year but is moving forward quickly now. Because this approach forms the basis for our community-based activities and because it will be so instrumental in promoting sustainability of PROVIC interventions, it's important to prioritize moving this approach forward rapidly this year.

Chemonics is working closely with the PROVIC field team particularly the community mobilization specialist to move the requisite steps forward quickly such as selecting the potential grantees for implementation and updating the terms of reference for those partners. In addition, we are working to organize the appropriate technical assistance for the critical step of training the partners in the approach and the development of the final menu of tools and materials needed.

Gabrielle Bielen (EGPAF)

Harmonization of consortium benefits package

Ms. Bielen obtained a draft copy of the ProVIC Policy Manual, which was shared with EGPAF/HR for review, comment, and harmonization. She requested a list of ProVIC holidays and found out that ProVIC follows DRC national holidays with the addition of July 4th and Christmas week. Ms. Bielen was able to verify that PATH and Chemonics staff are accruing vacation at 1.8 days/month and was able to discuss with the COP/DCOP and PATH and Chemonics program managers the mechanism for staff to request and take time off. Ms. Bielen followed up with the PATH Finance and Administration Specialist to understand the type of health benefits available for staff in DRC. Currently Chemonics is providing its employees with a type of benefit which allows free consultations. A relationship with a local hospital and clinic allows the facilities to directly bill PATH for other services provided. EGPAF noted their intent to participate in this system and was told by the Finance and Administrative Specialist that it should not pose a problem.

ProVIC-endorsed payroll company

Ms. Bielen found out that PATH and Chemonics are currently managing payroll for their employees in-house with consortium staff providing the services. Due to the contractual relationship and respective liabilities, EGPAF is not eligible to access this system. The PATH Finance and Administration Specialist has recommended PayNetwork, an external payroll company, which could provide payroll services for all consortium members, reducing tax and other liabilities. The consortium has not taken a decision to move to this payroll company, however should it decide to do so EGPAF is eager to be able to access the same payroll services used by other partners.

Sharing of ProVIC data

Ms. Bielen discussed data sharing with the M&E Specialist and Chemonics Program Manager and was assured that ProVIC data is available to all consortium members and will continue to be freely shared.

Follow-up of EGPAF registration process

Ms. Bielen met with the registration lawyer EGPAF had on retainer (paid for out of non-ProVIC funds). She was able to confirm that the lawyer had not taken any action on EGPAF's registration in the last 6 months and it was decided to terminate the relationship. The COP has offered to facilitate EGPAF's registration in the same manner that the IHAA's registration was facilitated by giving the COP power of attorney. Ms. Bielen is following up on whether this is acceptable to EGPAF senior leadership, but it appears they may be more comfortable providing POA to an EGPAF staff. Once EGPAF is registered, and healthcare insurance details are finalized EGPAF will place staff on a long-term contract.

EGPAF STTA discussions

Ms. Bielen had meetings with the COP/DCOP and EGPAF staff to discuss delays in Year 1 STTA on PMTCT and the continuum of care. The process that EGPAF goes through to apply for and mobilize STTA was discussed to expedite the process in the future. The year 1 STTA is now planned for November 2010. Ms. Bielen also discussed year 2 STTA priorities with the team and it was agreed that EGPAF would provide international TA for a Quality Improvement training and QI plan PMTCT that will take place in Q3.

EGPAF staff performance

Ms. Bielen conducted a joint meeting with the COP and DCOP to discuss the performance of the EGPAF staff in Year 1. Dr. Ditekemena was praised for his technical leadership and openness to help out with any aspect of the project –even if not directly related to PMTCT. The COP/DCOP noted that he is recognized as a leader and for his hard work. Dr. Katabuka was also complimented for having a strong work ethic and passion for the job. The COP commented that it was refreshing how quickly both employees had made the shift from "clinical mindset" to having a "programmatic mindset" and being able to think through broad programmatic issues and challenges. It was noted that these two are generally the first to arrive at the office in the morning and the last to leave. During the conversation Ms. Bielen noted the importance of keeping the PMTCT team connected to global EGPAF technical staff and resources so they can remain at the cutting edge of their field during their time with the project. Ms. Bielen will continue to look for opportunities for technical exchange (through emails, phone calls, etc.) with EGPAF staff who have experience with similar challenges and opportunities to participate in targeted technical workshops or exchanges.

Meeting with regional prevention specialists

Ms. Bielen was not able to meet with the ProVIC regional prevention specialists as they did not attend the Year 2 workplanning workshop in Kinshasa. She did have a discussion with John and Mitterrand and asked them to keep her in the loop if there are any resources, tools, or information EGPAF can share with the regional staff to help them with their work.

Meeting with Drs. Ditekemena and Katabuka to discuss their progress, challenges, and goals moving into the second year of the project

Ms. Bielen met with Drs. Ditekemena and Katabuka to discuss their year 1 challenges and progress. They reported really enjoying the work and the team, although noting that the atmosphere was often times stressful with numerous unscheduled, extremely long meetings. They reported that the collaborative approach used with EGPAF-HQ for writing reports and documentation is working for them – with email exchanges in track changes are helping them to develop and refine their deliverables. They noted that overall there was a lot of confusion in year 1 about the projects model and mode of action – but things were getting easier and since Q4 the team was really getting to work and things were going well. They expressed concern over their ability to provide quality PMTCT and pediatric care services given the current lack of drugs and commodities but expressed enthusiasm about continuing the discussions at the consortium, national and global level to secure the necessary inputs. They expressed interest in and asked for information about EGPAF's educational assistance benefit (unfortunately due to their current status as consultants they are unable to access this). They also both expressed their concern at the 18-month scope of Mitterrand's position –given the work the team must complete at the national, district, and site levels – it remains unclear how

sites, clients, AXxes, PNLS, district staff, and regional preventions staff can be supported with only one EGPAF employee.

Challenges and issues for follow-up

Harmonization of consortium benefits package

EGPAF remains concerned about the legal implications of putting staff on a long-term contract without an established medical insurance policy. EGPAF HR staff at the global level continue to research possible insurance schemes – such as the one utilized by Zain employees in DRC. In the meantime, EGPAF remains interested in continuing to learn about and hopefully follow the consortium-provided insurance package once it is finalized.

ProVIC-endorsed payroll company

EGPAF's access to a payroll system remains one of the biggest barriers to putting staff on a long term contract. Should the consortium move to work with PayNetwork EGPAF would be eager to participate in the system. Should ProVIC be able to run EGPAF payroll along with that of PATH and Chemonics EGPAF would be appreciative – but to date this has not been acceptable to senior level staff at PATH and Chemonics due to implied liability.

Follow-up of EGPAF registration process

EGPAF is in the process of terminating the retainer with the previous registration lawyer and will get approval to give Power of Attorney to a DRC staff member to facilitate the registration process along with the ProVIC administrative assistant.

Progress, challenges, and goals moving into the second year of the project

Ms. Bielen and Dr. Ditekemena will prepare a justification to the PATH/Chemonics team for extending the term of employment for the Pediatric Specialist. The EGPAF team will continue to work with PATH and Chemonics to secure the required commodities for ARV prophylaxis and care in order to allow the project so support the provision of high-quality clinical services.

Simon Mollison (IHAA)

Support to Alliance staff in reflection on Year 1 and planning for Year 2

- Detailed discussions with Alioune Badara Sow (Care and Support Adviser, recently arrived in DRC) concerning previous performance under ProVIC's care and support program.
- Participation in the ProVIC Year 2 planning workshop.
- Follow-up work with Elyse Zambite (HSS Adviser) and Alioune Sow to agree strategies for the Year 2 plan and to review early draft of plans.

Supportive supervision of Alliance Kinshasa based staff

- Dealing with issues (including those related to employment contracts, housing,
- Discussion with Elyse Zambite concerning his performance over Year 1, the challenges faced and his role in Year 2.
- Briefing both on imminent restructure of the Alliance's UK office.

Discussion and planning recruitment of vacant position in Kinshasa team

- Discussions with Alioune Sow about the required skill set; agreed to look for a medically qualified HBC adviser.
- Discussions with ProVIC management concerning recruitment arrangements.

Challenges and issues for follow-up

Health systems strengthening

- It is clear that HSS work needs to be closely integrated with the other two components and that it will become more energized as the care and support work becomes energized.
- Essentially we need to develop a loop so that we engage with provincial authorities to support and supervise the work we do in communities and then help then to use this experience to extend their capacity and reach to other initiatives within their provinces.
- The component may be misleadingly named as there is also apparently a big need to build the capacity of MINAS – particularly in relation to care and support for OVC. However, I do not think the component's name is causing any significant confusion in practice. The importance of MINAS to the project comes partly from an expressed desire of USAID and I assume this requirement will continue despite personnel changes.
- There is a need to increase the focus on work to build the capacity of the relevant provincial government agencies to collect and make effective use of data concerning needs and the performance of the services they are responsible for.

Care and support

- The care and support packages (for PLHA and for OVC) inherited from CRS are adequate as a description of needs but somewhat generic. They seemed to lack analysis of the Congolese context and a consideration of operational strategy.
- The intended approach was probably based upon the provision of “packages” to meet these (generic) “needs”. But there has been little consideration of how well the needs of both groups (PLHA and OVC) can be met by community structures.
- Effective community mobilization (see also below) can greatly strengthen the relevance, cost-effectiveness and sustainability of ProVIC's care and support activities.
- Of course, some needs will require significant support from the project.These include ensuring access to, and quality of, essential services – most obviously health services – as well as the likely need to provide support for addressing poverty.
- In this context, there is a need to clarify the extent to which apparent needs for nutrition interventions concern knowledge (about healthy eating) or whether they are therapeutic or economic needs (as the three types of need require very different interventions).
- So, a focus on strengthening essential services remains vitally important. Even in this, though, the role of mobilized PLHA in ensuring access to services for PLHA, and in ensuring good referral systems, is an important strategy.

A note on economic activities

It is recognized within the project that activities that generate or support income can be significantly useful for addressing a wide range of care and support needs in a sustainable way. Such initiatives can be complex and require expertise:

- To understand markets.
- To ensure that "processes" (e.g., for agriculture or manufacture) are technically sound and feasible.
- And to choose and develop appropriate ownership arrangements (e.g. entrepreneurship versus cooperatives or an arrangement incorporating both) – with awareness that significant incomes can be divisive and can damage newly created institutional structures.

Given that this expertise is not central to the project's mission, some simplicity is advised. At the same time, the project should explore opportunities to leverage knowledge and support in community-based economic strengthening. It is noted that the Champion Community model should be able to provide a good institutional base for economic strengthening activities.

Conclusions

- It will be important to include in the plan for Year 2 an audit of current approaches to care and support (in comparison with what we know to be good practice) in the project's implementation areas and to ensure that the care and support team are able to undertake such assessments when needed.
- There will be a need to monitor the extent of needs for therapeutic nutrition (i.e. of severe wasting) amongst PLHA and to look at ways of addressing these if necessary.
- While economic strengthening is likely to be important for ensuring a sustainable care and support response, there will be a need to tread carefully and slowly in the beginning.

Community mobilization and champion communities

- Community mobilization is a broad term that can mean a variety of things in different contexts and for different purposes. Community mobilization is to be a key strategy for care and support within the project. It involves the mobilization of PLHA within communities so as to develop supportive mechanisms and practices and so as to identify areas where our support is needed.
- This is not the same thing as (but can easily be fully compatible with) the Champion Community roll-out. Community mobilization for care and support needs to be rolled out rapidly (and needs to move alongside the roll out of prevention activities), while the Champion Community work will be rolled out more slowly. Champion communities, where present, will represent a significant resource for care and support (but care and support activities cannot be reliant solely on the presence of a functioning Champion Community).

Conclusions

- The care and support work will use a community mobilization strategy for PLWHA based upon the positive living concept. This will also result in access to OVCs (through PLWHA families). An additional strategy with OVCs will be based upon the child to child methodology (see below). These initiatives will strengthen the ability of PLWHA and OVCs to leverage support within champion communities.

OVCs

- A key approach to OVCs has to be through their families. Mobilization of PLWHA is thus an important entry point for care and support for OVCs.
- The use of the child-to-child methodology is a significant additional approach for care and support for OVC and, in some respects mirrors the mobilization of PLHA.
- A significant involvement of previous approaches to OVC has involved providing "school kits" and school fees to enable OVCs to attend school. This is not sustainable. It is also probably an ineffective method for ensuring that OVC get an education – and, if this is our aim, we should expect to focus more of our attention on strengthening schools and schooling. Such activities might fit very well within the Champion Communities approach.

Conclusions

- There will be a need to undertake assessments of how well schools serve children (looking at such questions as whether enrolled children attend regularly and whether they achieve results – literacy, exam passes etc. – from their attendance) as well as to develop community and/or family initiatives that support the inclusion of OVC in schools.
- Child protection is likely to be an issue that emerges from care and support work and we will need to be equipped to pick up these issues.
- A relatively early piece of STTA will be needed to provide support in addressing these two issues.

A Note on management of implementation

- So far there has been significantly less implementation under the care and support component than under the prevention component. Less implementation equals less opportunity to learn from the environment.
- The choice of ProVIC partners to be granted for implementing project activities is advancing but still faces challenges. For example, chosen partners will need to develop and agree work plans and budgets that fit within the project's overall operational intentions as well as the work plans that are being developed. Much of what has been planned within the Alliance-led components depends upon this process moving smoothly past the inevitable hiccups. Significant leadership from the project will be needed to ensure that this is so.